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Blue Cross Association
Blue Shield Association

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September 14, 1979

TO: Chief Plan Executives

FROM: Edward S. Mills, Vice President, Health Economics Research

SUBJECT: Economic Report

IN THIS ISSUE;

General State of the Economy

Recent trends - The economy is experiencing rapid inflation at the same time as economic activity is slackening. As long as the rate of unemployment remains below 7 percent, the Administration and the Federal Reserve will probably continue to concentrate on restraining inflation, primarily through higher interest rates, rather than stimulating the economy through tax cuts or other fiscal measures. (p. 3)

Price restraint - In the latest 12 month period, July 1978 to July 1979, the CPI index of medical care prices increased at a slower rate than inflation, (9.3 percent vs. 11.3 percent). This shift in relative prices may have contributed to the increase in demand for medical care services reported by the AHA and Plans. Increases in inflation and utilization are putting pressures on hospital costs, may complicate the rate making prices, and may make compliance with the "voluntary" price standards difficult. (pp. 3, 4)

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IN THIS ISSUE;

- continued -

Interest rates - Higher interest rates will favorably affect Plan investment returns. However, they also encourage accounts to bargain harder over matters relating to cash flow, delayed payments, and interest on unearned premium income. Inflation adds additional incentives to this latter factor. (pp. 4, 5)

Employment - Sharp gains were registered from 1977 through the first quarter of 1979. However, employment growth has slowed. A reduction in hours worked in the second quarter may have contributed to increased utilization by enabling workers with shorter hours to schedule discretionary medical care. (pp. 5, 6)

Unemployment - The rate may reach 7 percent of the labor force by year end, up from the 6 percent rate reported in August, and may increase utilization over those rates that prevailed during the economic expansion. (pp. 6, 7)

Account Specific analysis - This issue of the Economic Report includes an example of the claims experience analysis now being developed in the Health Economic Research Department. Reports can be generated for Plan specific analysis, account specific analysis, and provider specific analysis. They will be used by various Plan personnel in account meetings, provider relations meetings, rate hearings, and for documenting Plan cost containment savings. (pp. 9, 10, 11)

GENERAL STATE OF THE ECONOMY

Recent Trends

The Administration's economic priorities are energy and inflation. It is trying to get its energy program through Congress and convince the American people of the need to conserve energy. Meanwhile, inflation continues to put upward pressure on the wage-price spiral and to undermine the value of the U.S. dollar in foreign exchange markets. Economists say that the economy is in, or about to enter, a recession. However, the Administration is not using its economic tools to abort, or avert, the recession because unemployment has not yet become a major problem and several economic indicators, including sales and income, which were gloomy in the spring, have recently shown signs of improvement. The somewhat better tone of recent economic reports has softened the worst fears about the steepness of a decline in business activity, and enabled the Federal Reserve to continue to tighten monetary policy in order to combat inflationary pressures.

Impact of anti-inflation program on Plans

a. Price restraint

The administration has tried to restrain inflation in the health care sector through the passage of legislation which would cap hospital expenses and the adoption of "voluntary" price standards that limit increases in carrier and provider charges.

The health care sector, under the aegis of the Voluntary Effort (VE), has conducted its own anti-inflation initiative. That initiative has focused on increasing the cost effectiveness of the health care delivery system by reducing the rate of increase in hospital expenses, freezing the number of hospital beds, reducing capital investment in the hospital industry, restraining physician fees and other medical care prices, and introducing a series of measures to improve productivity. These actions have enabled medical care prices to increase at a slower rate than prices of all other goods and services. For example, in the first seven months of 1979, the CPI index of medical care increased at a compound annual rate of 9.3 percent, while the all items index increased at a compound annual rate of 13.9 percent, unadjusted.

The slower rate of increase of medical care prices relative to other goods and services may have provided an inducement for increased consumption of medical care. The AHA panel survey reports that in the first six months of 1979, adjusted admissions increased 2.6 percent, in contrast to a 0.8 percent increase for the corresponding period in 1978. In that same six month period, surgical operations increased 4.7 percent, and births increased by more than 5 percent, in comparison with no changes in the corresponding period in 1978. Many Plans are reporting that utilization declines experienced over the past several years are bottoming out, and other Plans are reporting utilization increases. The increase in hospital utilization has resulted in an increase in hospital costs as hospitals strive to maintain quality service with an increased patient load. Hospital expenses increased 13.2 percent in the first six months of 1979, compared to a 12.9 percent increase for the corresponding period in 1978.

The VE has asked hospital administrators, chiefs of medical staffs, and hospital boards to hold the line on employment and to look closely at utilization and staffing patterns in a continued effort to contain costs. The 1980 VE goals focus on improving and expanding medical staff utilization review programs and increasing hospital productivity. However, additional cost pressures can be expected as the sharp increase in the price of energy moves through the economy and affects the price of petroleum-based items such as pharmaceutical supplies, plastic disposable implements, and fuel. If hospital expenses continue to increase at an accelerating rate, a Plan's ability to comply with the Administration's price standard for health insurers could be impaired. (The second program year of the Administration's "voluntary" program of wage and price standards begins October 2, 1979. However, the second program year's price standard for health insurers will not become effective until sometime in 1980. The price standards for the health insurance industry are not expected to be announced before December, 1979.)

b) Interest rates

The Administration has tried to contain general inflationary pressures by a policy of monetary restraint. This has increased interest rates. This increase has had a favorable impact on Plans' investment income. For example, the rate of return on Blue Cross Plans investment income on June 30, 1979 was 8.33 percent, up from 6.59 percent reported on September 30, 1978. The rate of return on Blue Shield Plans investment income was 8.18 percent on June 30, 1979, compared to a 6.11 percent rate of return on investment income on September 30, 1978.

Over the past three months, monetary policy has been tightened. The Federal Reserve, citing "strong inflationary forces", has pushed the federal funds rate to 11-3/8 percent from the 9-3/4 - 10-1/2 percent that prevailed this spring. (The federal funds rate serves as a base for determining other short term interest rates.) It followed the increase in federal funds rate with an increase to a record 10-1/2 percent, from 10 percent, in the discount rate, the fee charged on loans to member bank reserves. Since then, the prime rate, the interest rate banks charge their best customers, which had been moving downward in the spring, reversed its trend and moved up. The prime rate is presently 13 percent, which is above the record 12 percent reached in 1974, and the 9 percent rate in effect at this time last year.

Economists are predicting higher interest rates in the near future. Paul Volcker, new chairman of the Federal Reserve, said that interest rates are likely to remain high as long as inflation continues at a torrid pace. "I know of no way to get those interest rates down in the present environment." Before the recent moves by the Federal Reserve, many banks thought interest rates were close to their peak. However, that sentiment has changed as the money supply and inflation continue to soar, and recession-induced inventories pile-up.

The rapid growth of the money supply in the past 4 months has eased the impact of tighter credit and prevented a credit crunch. Meanwhile, inflation is providing a strong incentive to borrow. With inflation running in excess of 13 percent, not only are borrowers repaying loans in cheaper dollars, but

the cost of postponing a purchase rises significantly. The pile-up of inventories, which has resulted from the economic slowdown, has increased many companies' need for credit. Thus, loan demand has soared in recent weeks. Many money analysts are predicting that interest rates will reach 13-1/4 - 13-1/2 percent in the near future. Plans may want to reexamine their investment portfolios.

The high market rates of interest in 1973-74, 1978, and now have increased the incentive for managers to implement new cash management techniques. Reports indicate that large corporations began to modify their cash management procedures starting about 1973, and that many smaller corporations began to utilize the newer techniques during the past two years. Thus, as interest rates rise, accounts can be expected to bargain even harder, and to shop around even more, for arrangements which will enable them to hold on to their own claim reserves. In addition, accounts which draw interest on cash left with Plans can be expected to demand increased interest rates.

High interest rates could result in an increase in Plans' accounts receivable. It would also increase providers' bad debts and delinquencies, and reduce charitable contributions received by hospitals. This may provide an opportunity for Plans to enter into participation agreements with hospitals and other providers which are not currently parties to such agreements.

Impact of economic slowdown on Plans

a. Demand for fringe benefits

In general, unions find it more difficult to win sharply higher increases in wages and fringes in periods of economic slowdown than in periods of economic expansion. This is because profits are squeezed and employers do not feel the need to attract new workers, or to sustain employee morale. In a period of recession and inflation, as occured in 1974-75 and now, the emphasis in many unions is to bargain for improvements in COLAs, pensions, and benefits related to job security. In addition, because of the dramatic increase in health care costs, unions continue to be anxious to obtain conversion contracts for health benefits, as well as new benefits, such as dental and vision care. General Electric recently adopted a dental plan for the first time, and Goodrich raised the benefits for outpatient treatment, physical therapy, and major medical.

b. Slowdown in the growth of employment

The growth of nonfarm employment from the end of 1977 to the first quarter of 1979 was quite vigorous. This robust demand for labor reflected increased spending for non-residential construction activity supplemented by strong demands for housing, consumer goods, and capital equipment. However, since March employment growth has moderated appreciably. In general, service-producing industries grew slowly in the second quarter, while goods-producing industries, posted employment declines.

As economic activity has slowed, employers have reduced overtime and the length of the workweek. The reduction in the work-week has provided many workers with additional time to schedule discretionary medical care, and may have contributed to the rise in utilization that occurred in recent months. In addition, while

the reduction in hours worked does not reduce Plan enrollment, it does increase the percentage of payroll attributable to the cost of health benefits, and could make some employers reluctant to expand health benefits when contracts are renewed.

c. Unemployment

The rate of unemployment remained basically unchanged between July 1978 and July 1979. In August, the rate of unemployment increased to 6.0 percent, and economists are predicting further rises in the months ahead.

However, unemployment generally does not increase rapidly during the early stages of a recession. For example, in the 1973-75 recession, the most severe of the post-war period, employment rose by almost 500,000 in the first several months of the downturn, and did not begin a serious slide until almost a year after the recession began. In the final half year of that recession, employment declined by about 2 million, and the unemployment rate soared to 9.1 percent from its prerecession low of 4.6 percent, and from less than 6 percent almost a full year into the recession. Nevertheless, this pattern represents diverse employment changes in various industries. For example, the recessionary impact first occurred in late 1974 for total nonfarm payroll employment, but the largest goods-producing division - manufacturing - was effected in early 1974 and experiences six quarters of declining enrollment. Meanwhile, service-producing industries, e.g., trade, finance, services, did not have employment declines until early 1975, and then for only one quarter. In contrast, two industries, mining and government, had no recession-related job declines.

Hospital admissions generally rise during recessions. (See Table 1.) This is partly attributable to the increase in illnesses related to stress, as well as a surge in demand for hospital services from workers who have been laid off and are seeking to use their health benefits before they expire. In the last recession, real GNP declined by almost 5 percent, hospital admissions increased by almost 4 percent, and hospital expenses increased by 15 percent. Blue Cross hospital utilization was sharply affected by the recession in the fourth quarter of 1974 and first quarter of 1975, the two quarters when real GNP and employment plunged sharply.

The economic slowdown has already had an impact on the automobile industry. In real terms, automobile sales fell 11.5 percent during the first six months of 1979, and inventories increased sharply. However, sales have increased from their June low, and are running 6 percent below last year. Industry analysts are predicting that 1979 sales will be 10.5 - 11 million units, down from the 11.3 million units sold in 1978.

Meanwhile, approximately 81,500 automobile workers are on indefinite lay-off (28,300 Chrysler, 34,000 GM, 18,000 Ford, and 1,200 AMC). Approximately 20 percent of the Chrysler work force has been laid-off. Chrysler's financial problems will not be solved in the near future. Sources close to the industry are predicting that Chrysler will be reorganized and will emerge from its financial crisis as a much smaller concern.

However, lay-offs in the automobile industry do not generally result in a sharp increase in the utilization of health benefits. This is because the health insurance coverage of UAW members continues for as long as workers are eligible for

supplemental unemployment benefits from an employer-financed fund. The length of time a worker draws supplemental benefits is related to his seniority. Supplemental benefits generally provide a UAW worker with approximately 90-95 percent of his paycheck and may last up to 13 months. This is often longer than workers are unemployed. An automobile worker receiving 90 - 95 percent of his paycheck and who anticipates being employed before his health benefits expire generally is not inclined to utilize those benefits during the period he is not employed. Detroit hospitals reported little change in admissions during the last recession.

Industries which supply the automobile industry have also begun to lay off workers. The Toledo based Libby-Owens-Ford Company laid off 430 workers, or 2.3 percent of its glass division, Firestone Tire and Rubber Company laid off 1,400 auto and light truck tire workers, and Goodyear announced the shutdown of its bias-ply tire plant in Los Angeles, eliminating 1,225 jobs.

These reductions could be dwarfed by impending work force cuts in the steel industry. Orders for steel used to make capital goods have leveled off and orders from consumer related industries are falling. David Roderick, President of U.S. Steel, expects the industry's third quarter shipments to drop 10 percent below the second quarter's 26.6 million tons, followed by another decline in the fourth quarter. Steel trigger prices, which are used to guard against cut-rate imports, were left unchanged for the fourth quarter by the Treasury Department. Lewis Foy, Chairman of Bethlehem Steel and Chairman of the Iron and Steel Institute, said that the unchanged trigger prices "can only encourage increased steel imports at a time when domestic steel production is falling." Some steel analysts are predicting that lay-offs of the 350,000 - 400,000 steel workers will increase by the same percentage as shipments by domestic manufacturers fall. In the last recession, utilization of health benefits by steel accounts increased even though health benefits of many USW workers continued for up to one year.

Nevertheless, even if unemployment does increase, as government and private economists are predicting, this may not have as significant an impact on utilization as in past recessions. There has been a sharp increase in the number of families with double incomes, e.g., more than half the net increase in the labor force since late 1977 has been concentrated among women. If one member of a family continues to be covered by a health insurance program, utilization of health benefits may not be sharply effected by an increase in unemployment.

Conclusion

The months ahead contain challenges for Plans. Economists are predicting increased unemployment (perhaps 1 million workers), continuing inflation, and higher interest rates. This could result in increases in utilization and hospital expenses. Meanwhile, Plans have indicated that they intended to comply with the price standards which call for decelerating trend factors used in calculating premiums. At the same time, competition between carriers, which already is intense, could increase still further as accounts seek the lowest possible premiums and the most favorable cash flow arrangements.

TABLE 1

Activity in Community Hospitals
During Recessions

	Percentage growth in community hospitals		
Period*	Expenditures	Admissions	Personnel
1946-47	22.7	16.5	6.6
1953-54	8.8	1.6	8.0
1957-58	11.8	3.2	6.2
1969-70	17.7	3.5	5.7
1973-74	15.0	3.8	6.5

Source: American Hospital Association, Hospital Statistics. Chicago: AHA, 1978, p. 7.

*These are recessionary periods showing an annual decline in real GNP; thus, the 1960-61 recession is excluded. This evidence was originally presented by: Raske, K. E. Recession implications for the hospital industry. Chicago: Bureau of Research Services, American Hospital Association, January 24, 1975.

Physician Reimbursement Study
Analysis of Claims Experience
Blue Shield of Maryland 1973-1976

For the past several years, Health Economics Research has been engaged in an extensive and most significant data base project known as the Physician Reimbursement Study. This project is funded by the Health Care Financing Administration of HEW and is being conducted jointly by the University of Southern California and the Blue Cross and Blue Shield Associations. Twenty Plans are participating in the study. To date the data from four Plans has been extracted and included in the initial research data base for Health Economics Research. Data from six more Plans is in the final extraction stage.

It should be noted that never before has a data base of this dimension and volume been constructed in the health care field. While only the most pertinent procedures or services are analyzed for efficiency purposes, the annual volume of data for any one Plan is typically greater than one million records and can be greater than that depending upon the Plan size.

As medical care costs continue to rise, it has become increasingly important for Plans to demonstrate to accounts the precise effects of price and utilization increases, within which sectors of the business these increases are most pronounced, and what their effects have been upon benefit expenditures. With the ability to quantify this kind of experience and interpret it meaningfully, Plans will be able to enhance their marketing efforts and justify necessary rate increases.

The most extensive analytic work has been performed on data from Blue Shield of Maryland, the first Plan to submit data. As many as 29 different data elements are extracted for each claim registered on the paid history files at the participating Plans. This allows special analyses to be performed for national accounts. Working with Robert Heird and Eleanor Bell at Blue Shield of Maryland, Health Economics Research staff identified significant charge, allowance and utilization trends for four major accounts.

The basic analytic tool being employed is a comprehensive indexing system which generates ten different indices. Included are four price indices, four quantity indices, a value index and an "ideal" index. Additionally, the quantity index is adjusted for contract changes to produce a true utilization index. This indexing system developed by the Health Economics Research Staff is supported by a computerized reporting mechanism which aids in the identification and analysis of cost and expenditure trends over the time period of the study, 1973-1976. The system allows annual changes to be described in percentage terms and the reporting mechanism encompasses the following four major categories:

1. Prices
2. Allowances
3. Utilization
4. Expenditures

The goal in developing the indexing and reporting system has been to make the data base most useful to Plans for both internal and external purposes. Applications thus far have been most useful in the Marketing, Provider Relations, Actuarial and Research areas.

As well as quantifying important cost trends by line of business and type of service, the reporting system is capable of addressing ad hoc administrative questions that may be very important. For instance, once it is known that the obstetrics area for the UCR program has experienced an inordinate utilization increase, it can further be determined which accounts were responsible, within which part of the state the plants are located, whether or not the increase occurred for bargaining or non-bargaining groups and if participating or non-participating physicians were associated with this change.

Another application has been to measure the lag time between the date of service and the date of claim payment. Both dates are captured in the extraction process. Hence, it is possible to identify excessive payment lag times by specific procedure, by physician specialty, by area of the state and by other categories.

The data base and the indexing system can also be used to address certain policy issues. Does the change in the copayment arrangement for certain contracts have a significant effect on service utilization? Is it possible to quantify the effect on utilization of changing from an 80-20 percent copayment contract to a paid-in-full contract?

Another avenue of investigation might be to compare charges and allowances for various diagnostic services by place of treatment. It may be that charges or allowances differ inordinately when rendered at a certain location (office as opposed to clinic). It would also be pertinent to determine if utilization of in-patient diagnostic hospital services increases for groups which are not covered for these services on an out-patient basis. Another approach to utilizing the data that has proved extremely valuable has been in the identification of significant intensity shifts. These shifts may be identified within lines of business, accounts, types of service and other subgroups within the Plan business. An example of this application is shown in Exhibit I of the attachments.

The Maryland Blue Shield analysis addressed many of these issues and more. Included in this report are several of the major findings. The data from accounts in the communications, ferrous metals and automotive industries indicate that major benefit expenditures have shifted out of the medical type of service (primarily hospital visits) and into areas such as pathology and radiology. Exhibit I compares the distribution of dollars charged by type of service in 1973 and 1976, based upon the combined experience of these accounts. In 1973 the medical type of service accounted for 34 percent of total dollars charged, while in 1976 this had declined to 24 percent with a rather even increase in each of the other types of service.

Exhibit II depicts the percentage change in charges, allowances, and utilization by type of service between 1973 and 1976 for these accounts. As may be noted, overall charges increased about 30 percent, while Plan allowances increased about 20 percent and utilization increased only 3 percent. The types of service which contributed most heavily to these increases are easily

identified. The area of anesthesia experienced the greatest percentage increase in charges and allowances. Diagnostic radiology and pathology experienced the greatest utilization increases, while medicine experienced a utilization decline. One can further analyze this phenomenon to determine which procedures were responsible for these changes.

For instance, within the area of radiology the two most cost significant procedures, "chest x-ray, 2 views" and "stomach-UGI complete" experienced sizeable utilization increases between 1973 and 1976 in the order of 75 and 39 percent respectively. Within pathology the most cost significant procedure was the "pap test" which experienced a utilization increase of 78 percent between the four years. For the medical type of service there was a dramatic decline of about 60 percent in the "normal hospital visit," while the "hospital visit with a comprehensive examination" displayed a very large utilization increase.

Certain procedures within the obstetrics area experienced significant increases in both charges and utilization. For a "cesarean section" utilization increased 137 percent during the study period, while charges increased 38 percent. Utilization for a "therapeutic abortion" increased by 33 percent, while average charges increased by only 7 percent. Overall, charges had increased by 36 percent for the entire obstetrics type of service, while allowances increased by 18 percent. This provides a measure of the cost effectiveness of Blue Shield of Maryland's UCR administration.

Exhibit III compares the trend in charges experienced by the Maryland Plan with the trend in the physicians' fee component of the Consumer Price Index. Over the four year period physicians' fees rose nationally by about 36 percent while fees in the Maryland area rose by only 30 percent.

It can be seen from this brief overview that the data base project has many applications of a cost containment nature within many functional Plan areas and it has been developed with this in mind. Further important developments will include multiplan comparisons for specific accounts and also the inclusion of hospital payment data.

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INFLATION REPORT

Consumer prices continued to advance rapidly in July. In August, producer prices for finished goods climbed sharply (at a 14.1 percent annual rate) and provided little prospect of early easing of upward inflationary pressures.

Consumer Price Index (CPI)

The CPI-U index (urban consumers), which covers approximately 80 percent of the civilian population, increased 1.1 percent, unadjusted, in July, marking the sixth consecutive month in which prices increased at a rate of 1.0 percent or more. The CPI-W index (urban wage and clerical workers), which covers about 40 percent of the civilian population, increased 1.2 percent, unadjusted, in the June to July period. Inflation "seems to be chugging away," said Janet Norwood, chief of the Labor Department bureau that reports the statistic.

The Labor Department said that about two-thirds of the increase in July consumer prices was attributable to higher energy and home ownership prices. The June-to-July CPI-U increases in energy prices, transportation prices, and housing costs were 4.2 percent, 1.9 percent, and 1.3 percent, respectively.

Meanwhile, price increases continued to outpace income gains. Although average weekly earnings of workers on nonfarm payrolls were $221.40 in July, 7.2 percent higher than a year earlier, prices have risen by 11.3 percent in the same time period.

Real spendable earnings of workers (earnings adjusted for taxes and price increases) have declined in four out of the past seven months. In July, real spendable earnings of a married worker with three dependents were almost 4 percent less than a year earlier. They had dropped 2-1/2 percent in the previous year.

Medical care prices, CPI-U, unadjusted

The health sector's voluntary initiative to restrain costs, which has proceeded under the auspices of the VE, has contributed to medical care costs increasing at a more moderate pace than inflation. For example:

In the latest 12 month period (July 1978 to July 1979), the rate of inflation increased 11.3 percent, while

- Medical care increased 9.3 percent
- Physician services increased 9.6 percent, and
- Hospital and other medical care services increased 10.5 percent.

In the first 7 months of 1979, inflation increased at a compound annual rate of 13.9 percent, while

- Medical care increased at a compound annual rate of 9.3 percent,
- Physician services increased at a compound annual rate of 10.5 percent, and
- Hospital and other medical care services increased at a compound annual rate of 9.4 percent.

Thus, all of the medical care indexes are increasing at, or below, the CPI. (See Table 2 and 4.)

In the one month period June 1979-to-July 1979, the rate of inflation increased by 1.1 percent, while

- Medical care increased by 0.9 percent,
- Physician services increased by 1.2 percent, and
- Hospitals and other medical care services increased by 0.9 percent.

The June-to-July increase in medical care indexes of the CPI was larger than in previous months. However, providers of medical care generally adjust prices at the beginning of a calendar or fiscal year, i.e., January, July, or October, and these adjustments are reflected in the index over a two month period.

Medical care prices, CPI-W, unadjusted

In general, the CPI-W medical care price indexes increased at a somewhat more rapid rate than comparable indexes of the CPI-U. For the past several months, reported increases in physician services in the CPI-W have been greater than reported in the CPI-U, while hospital price increases are less than reported in the CPI-U. For example, in the last 12 month period, July 1978-to-July 1979, the following differences appear:

	CPI-W	CPI-U
- All Items	11.5	11.3
- Medical care	9.6	9.3
- Physician services	10.3	9.6
- Hospital and other medical care services	9.6	10.5

In the first 7 months of 1979, the following differences appear in the compound annual rate of price increase of

- All items	14.3	13.9
- Medical care	9.6	9.3
- Physician services	12.1	10.5
- Hospital and other medical care services	7.8	9.4

In the month, June-to-July, the following differences appear:

- All items	1.2	1.1
- Medical care	1.0	0.9
- Physician services	1.3	1.2
- Hospital and other medical care services	1.1	0.9

A Labor Department official indicated that for major categories, the CPI-W and the CPI-U show little difference in movement. However, sharp differences appear for certain categories due to the relative importance of the items within each index as well as different outlets and prices sample. Despite differences in CPI-W and CPI-U, rates of change, prices of health care services have increased at a more moderate rate than inflation.

Figure I

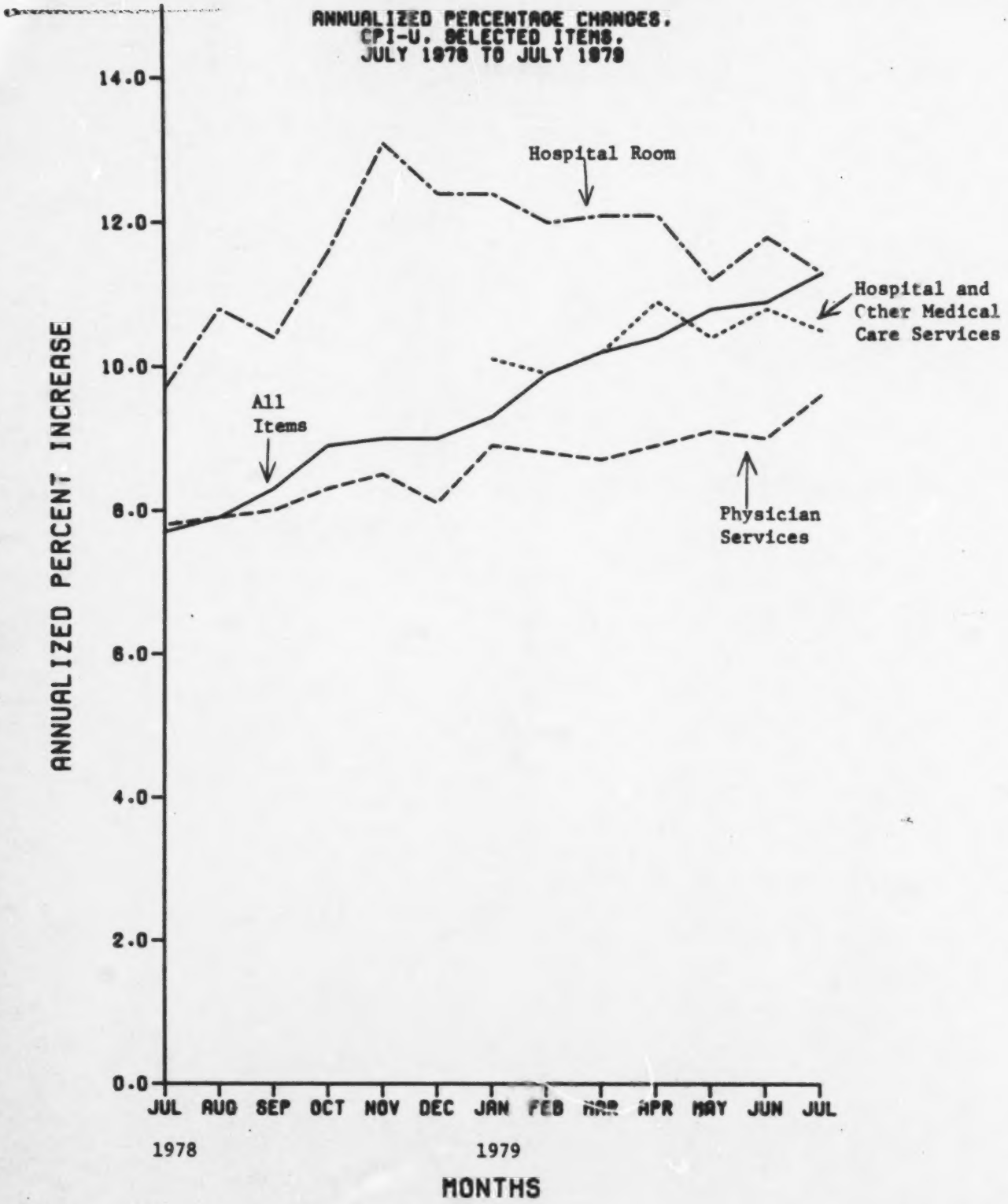

ANNUALIZED PERCENTAGE CHANGES.
CPI-U. SELECTED ITEMS.
JULY 1978 TO JULY 1979
ANNUALIZED PERCENT INCREASE
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Hospital Room
Hospital and
Other Medical
Care Services
All
Items
Physician
Services
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN JUL
1978
1979
MONTHS

Figure II

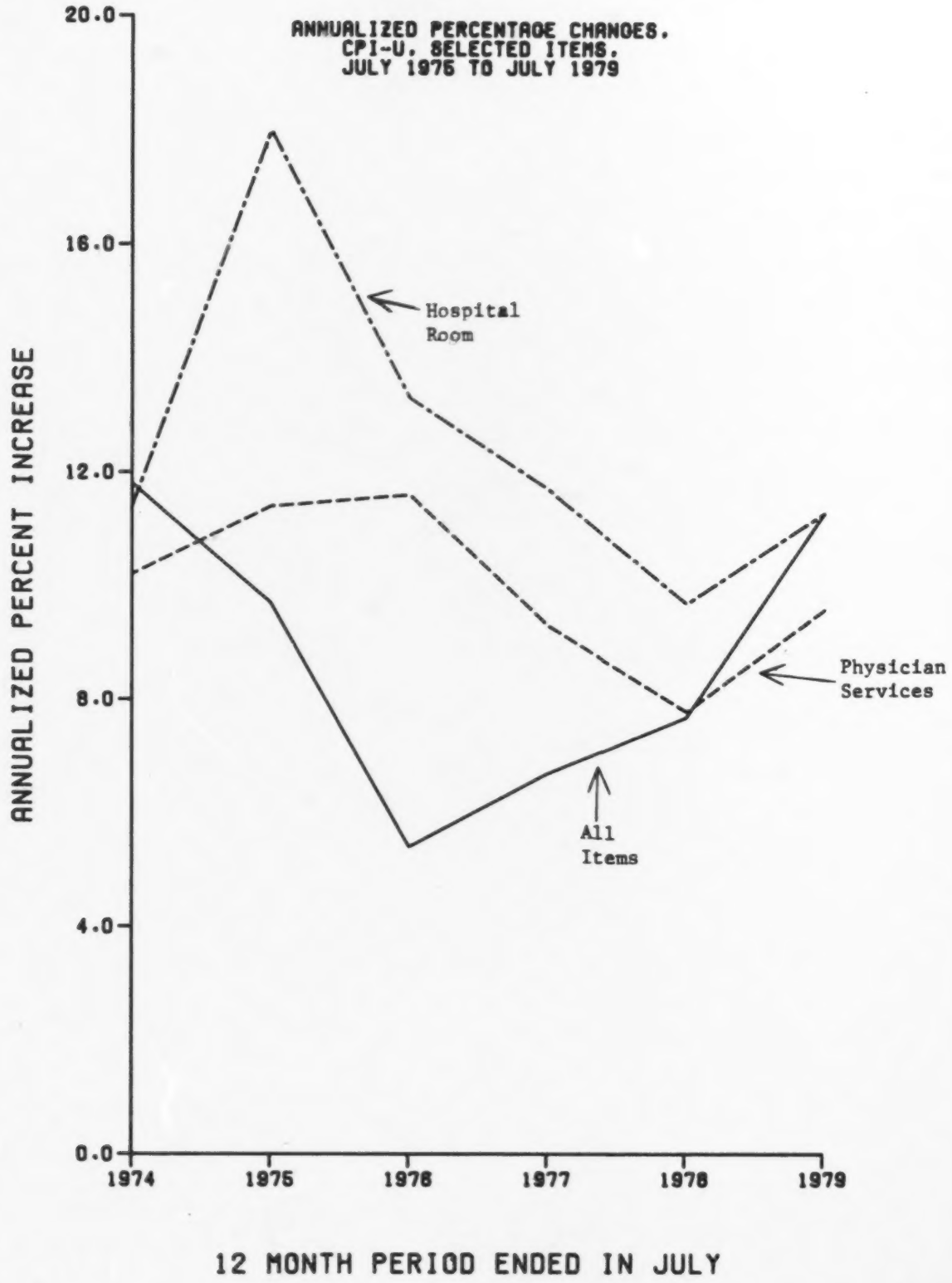

ANNUALIZED PERCENTAGE CHANGES.
CPI-U. SELECTED ITEMS.
JULY 1975 TO JULY 1979
20.0
16.0
12.0
8.0
4.0
0.0
ANNUALIZED PERCENT INCREASE
Hospital Room
Physician Services
All Items
1974
1975
1976
1977
1978
1979
12 MONTH PERIOD ENDED IN JULY

TABLE 2

Monthly Percentage for the Consumer
Price Index for All Urban Consumers (CPI-U),
Selected Items, All U.S. Cities
(Unadjusted)

EXPENDITURE CATEGORY	1978			1979							July 1978 July 1979
	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July	12 month
All Items	0.8	0.6	0.9	0.9	1.2	1.0	1.1	1.2	1.2	1.1	11.3
Medical Care	0.9	1.0	0.4	1.3	0.8	0.6	0.5	0.5	0.6	0.9	9.3
Medical Care Commodities	0.6	0.8	0.7	0.5	0.9	0.4	0.6	0.5	0.6	0.5	7.0
Medical Care Services	1.0	0.8	0.5	1.4	0.8	0.6	0.5	0.5	0.6	1.0	9.8
Professional Services	0.9	0.8	0.2	1.5	0.7	0.5	0.5	0.6	0.6	0.8	9.1
Physician Services	0.6	0.7	0.3	1.6	0.7	0.5	0.7	0.7	0.5	1.2	9.6
Dentist Services	1.1	0.6	0.8	1.6	0.7	0.4	0.5	0.5	0.9	0.4	8.9
Other Professional Services	1.0	0.4	0.3	1.0	0.5	0.1	0.5	0.7	0.4	0.8	7.4
Other Medical Care Services	1.1	1.3	0.4	1.4	0.5	0.6	0.5	0.4	0.6	1.1	10.5
Hospital and Other Medical Care Services	1.3	1.2	0.5	1.3	1.0	0.8	0.4	0.3	0.5	0.9	10.5
Hospital Room	1.8	1.3	0.5	1.5	1.0	0.6	0.3	0.4	0.6	1.0	11.3
Other Hospital and Medical Care Services	0.7	0.6	0.9	1.1	1.1	0.6	0.5	0.2	0.4	1.0	0.9
Services	1.0	0.5	0.4	0.9	1.0	0.8	0.8	1.1	1.1	1.1	10.9
Services, Less Medical Care	0.9	0.5	0.3	0.8	1.0	0.8	0.9	1.2	1.2	1.1	11.0

Source: Bureau of Labor Statistics

TABLE 3

Monthly Percentage Increase for the Consumer
Price Index for Urban Wage Earners and Clerical Workers (CPI-W),
Selected Items, All U.S. Cities
(Unadjusted)

EXPENDITURES CATEGORY	1978			1979							July 1978-July 1979
	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July	12 month
All Items	0.8	0.5	0.5	0.9	1.2	1.1	1.2	1.2	1.2	1.2	11.5
Medical Care	0.9	0.8	0.5	1.0	0.8	0.7	0.6	0.5	0.8	1.0	9.6
Medical Care Commodities	0.8	0.7	0.7	0.6	0.7	0.7	0.5	0.5	0.8	0.5	7.5
Medical Care Services	1.0	0.8	0.5	1.1	0.9	0.7	0.6	0.4	0.8	1.1	9.9
Professional Services	0.6	0.7	0.3	1.2	0.7	0.8	0.7	0.5	0.9	0.9	9.6
Physicians Services	0.6	0.7	0.3	1.1	1.1	0.8	0.8	0.6	0.9	1.3	10.3
Dentist Services	1.1	0.6	0.8	1.1	0.6	0.6	0.7	0.4	0.9	0.3	9.3
Other Professional Services	1.0	0.4	0.3	1.0	n/c	1.1	0.3	0.3	0.5	0.9	7.2
Other Medical Care Services	1.2	1.1	0.4	1.0	1.0	0.7	0.6	0.4	0.8	1.3	10.4
Hospital and Other Medical Care Services	1.3	1.2	0.5	1.0	1.0	0.4	0.5	0.3	0.5	1.1	9.6
Hospital Room	1.8	1.3	0.5	1.1	0.8	0.5	0.5	0.3	0.4	1.3	11.1
Other Hospital and Medical Care Services	0.8	1.1	0.4	1.1	1.1	0.4	0.6	0.3	0.5	1.1	9.3
Services	1.0	0.5	0.4	0.9	1.0	0.9	0.9	1.1	1.1	1.2	11.1
Services, Less Medical Care	0.9	0.5	0.3	0.9	1.0	0.8	1.0	1.2	1.2	1.2	11.3

Source: Bureau of Labor Statistics

TABLE 4

Percent Changes in CPI-U,
Selected Items, all U.S. Cities
(Unadjusted)

	Compound Annual Rate, 7-months ended July 1978	Compound Annual Rate, 7-months ended July 1979
All Items	10.0	13.9
Medical Care	8.4	9.3
Medical Care Commodities	7.7	7.2
Medical Care Services	8.7	9.8
Professional Services	7.1	9.5
Physician Services	7.9	10.5
Dental Services	7.1	9.0
Other Professional Services	6.6	7.0
Other Medical Care Services	10.1	10.0
Hospital and Other Medical Care Services	10.0	9.4
Hospital Room	11.4	9.6
Other Hospital and Medical Care Services	10.5	9.5
Services	9.8	12.4
Services, Less Medical Care	9.9	12.8

TABLE 5

Percent Changes in CPI-W,
Selected Items, all U.S. Cities,
(Unadjusted)

All Items	10.0	14.3
Medical Care	8.5	9.6
Medical Care Commodities	8.3	7.7
Medical Care Services	8.7	10.0
Professional Services	7.6	10.1
Physician Services	8.3	12.1
Dental Services	7.0	8.1
Other Professional Services	6.0	7.4
Other Medical Care Services	9.6	10.0
Hospital and Other Medical Care Services	10.3	7.8
Hospital Room	10.7	8.7
Other Hospital and Medical Care Services	10.1	8.7
Services	9.7	12.8
Services, Less Medical Care	9.7	13.2

Source: Bureau of Labor Statistics

TABLE 6

12 Month (July -to- July) Percentage Change in CPI-U, Selected Items, U.S. Cities

	July 1973-July 1974	July 1974-July 1975	July 1975-July 1976	July 1976-July 1977	July 1977-July 1978	July 1978-July 1979
All Items	11.8	9.7	5.4	6.7	7.7	11.3
Medical Care	8.2	12.2	9.2	9.7	7.8	9.3
Medical Services	11.3	12.6	9.7	10.1	8.0	9.8
Physician Services	10.2	11.4	11.6	9.3	7.8	9.6
Dental Services	7.8	10.6	5.5	8.0	6.5	8.9
Hospital Room	11.4	18.0	13.3	11.7	9.7	11.3
Services	10.2	9.2	8.5	8.1	8.4	10.9
Services, Less Medical Care	10.0	8.6	8.3	7.6	8.5	11.0

TABLE 7

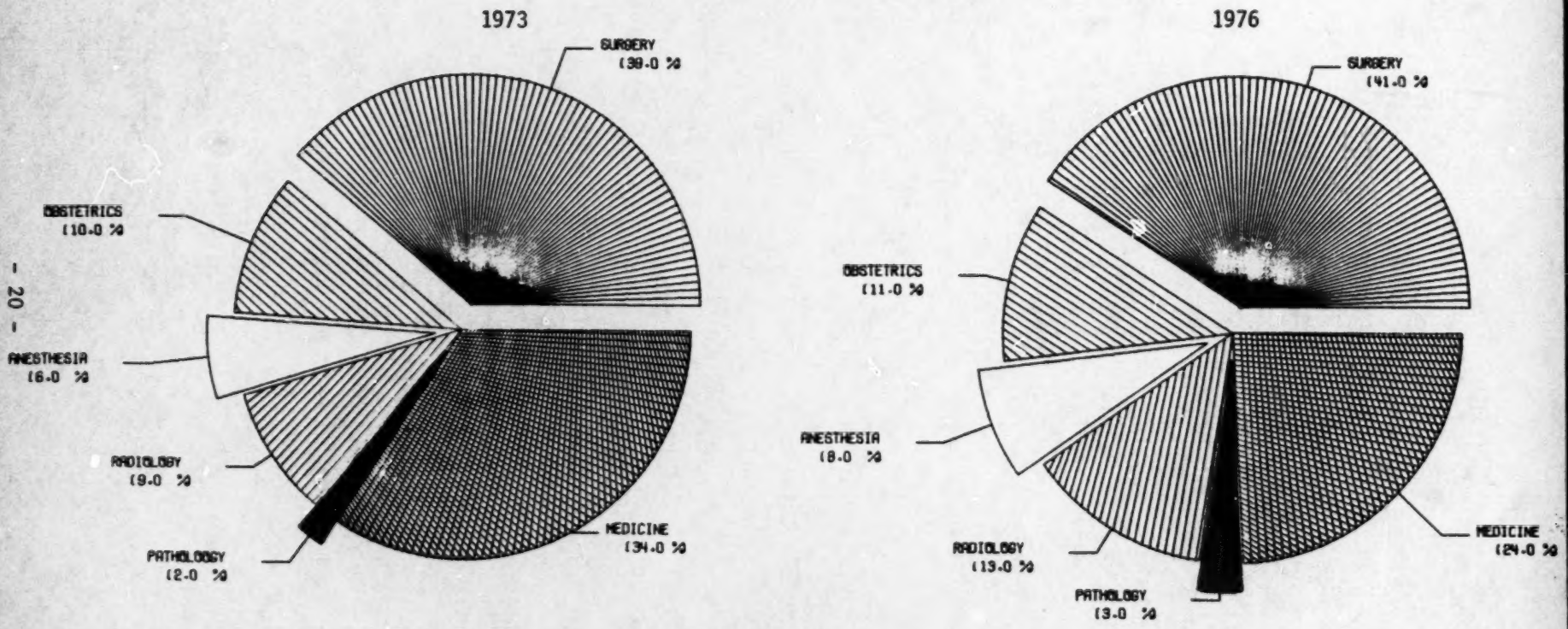
12 Month (July -to- July) Percentage Change in CPI-W, Selected Items, U.S. Cities

All Items	11.8	9.7	5.4	6.7	7.7	11.5
Medical Care	8.2	12.2	9.2	9.7	7.9	9.6
Medical Services	11.3	12.1	9.7	10.1	8.0	9.9
Physician Services	10.2	11.4	11.6	9.3	8.1	10.3
Dental Services	7.8	10.6	5.5	8.0	6.9	9.3
Hospital Room	11.4	18.0	13.3	11.7	9.4	11.1
Services	10.2	9.2	8.5	8.1	8.3	11.1
Services, Less Medical Care	10.0	8.6	8.3	7.6	8.4	11.3

Source: Bureau of Labor Statistics

EXHIBIT I

BLUE SHIELD OF MARYLAND
NATIONAL ACCOUNT EXPERIENCE
PERCENTAGE DISTRIBUTION OF DOLLARS CHARGED
BY TYPE OF SERVICE, 1973 VS 1976



BLUE SHIELD OF MARYLAND

EXHIBIT II

NATIONAL ACCOUNT EXPERIENCE
PERCENTAGE CHANGE IN CHARGES, ALLOWANCES
AND UTILIZATION BY TYPE OF SERVICE
1973 VS 1976

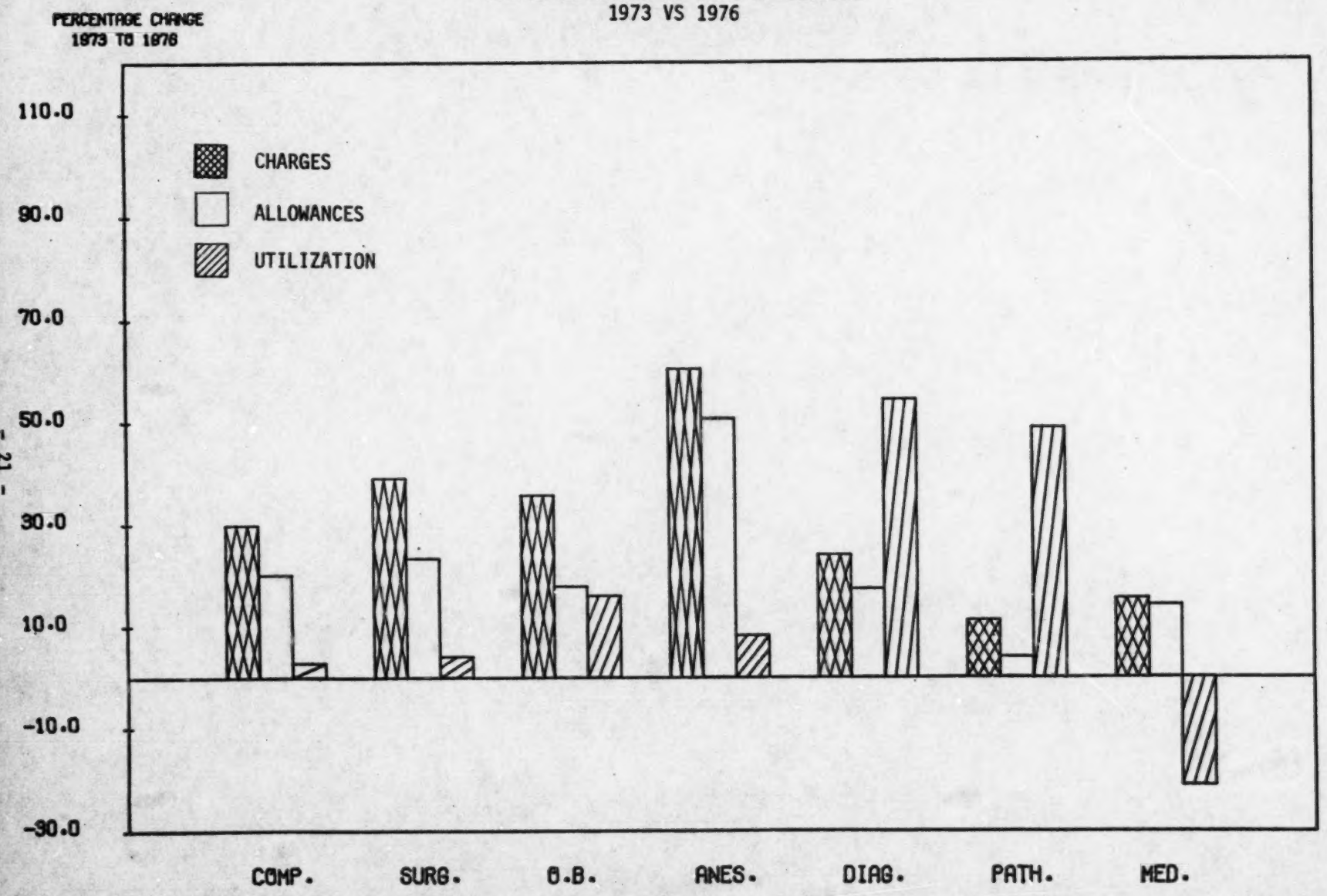
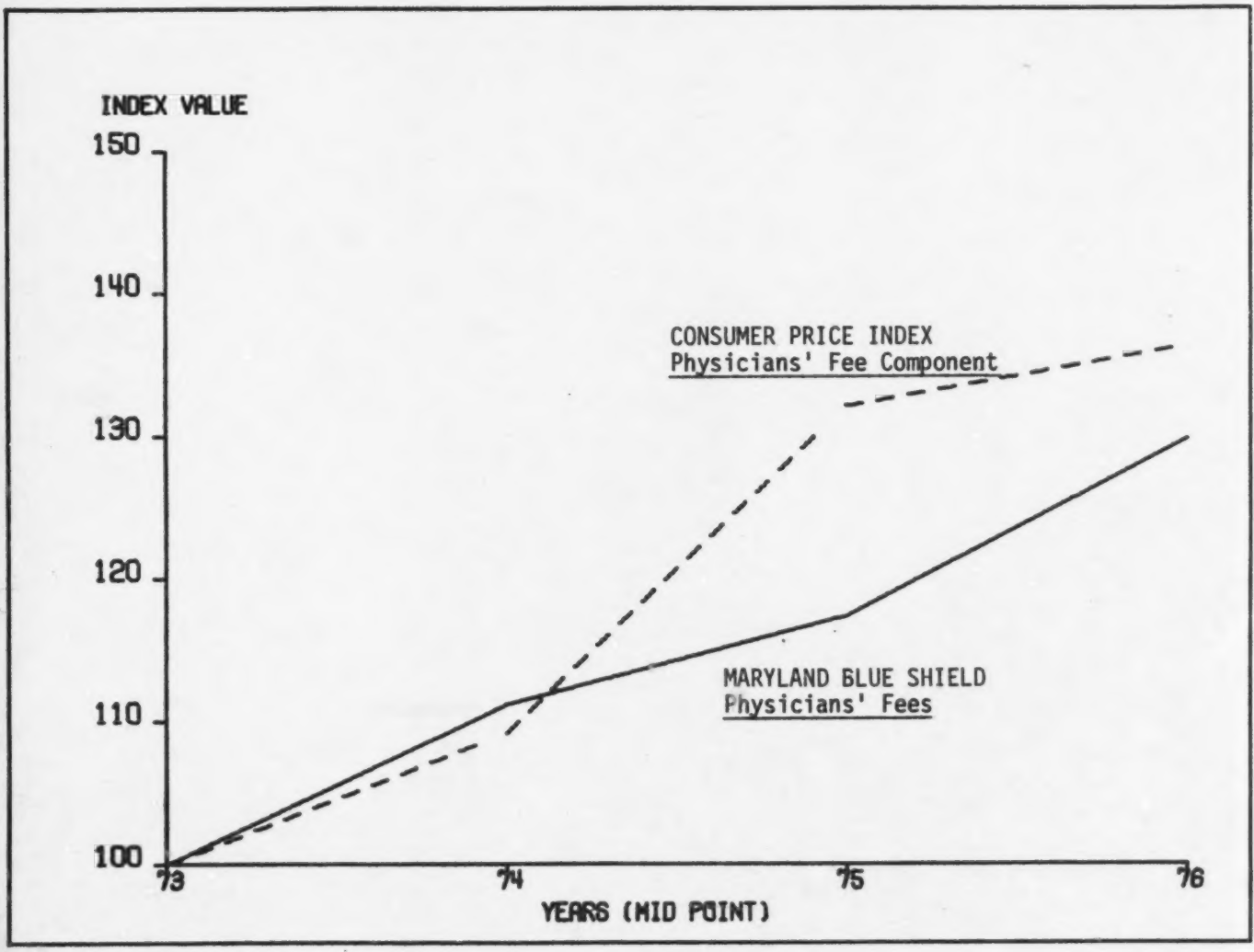


EXHIBIT III

BLUE SHIELD OF MARYLAND

NATIONAL ACCOUNT CHARGE EXPERIENCE
VERSUS THE CONSUMER PRICE INDEX
PHYSICIANS' FEE COMPONENT
1973 - 1976
1973 = 100.0



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OCT. 15 1979

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Blue Cross
Association
Blue Shield
Association

840 North Lake Shore Drive
Chicago, Illinois 60611
312/440-6000

October 15, 1979

TO: Chief Plan Executives

FROM: Edward S. Mills, Vice President, Health Economics Research

SUBJECT: Economic Report

IN THIS ISSUE

"Voluntary" Wage and Price Standards for 1980

The CY 1980 price standard for health insurers and voluntary guideline for nonfederal hospital expenditures will be announced later this year. The physician fee standard has been extended to the second year as a cumulative limitation by compounding 6.5 percent over two years. Thus, between October 1, 1978 and October 1, 1980, average physician fees may not exceed 13.4 percent.

The wage standard applicable to Plan employees has been eased. The Pay Advisory Committee is responsible for recommending a new wage standard. In the interim, Plans who are in compliance with the wage standard, and whose workers are not covered by a COLA clause, may increase wages by 8 percent. Increases in excess of 8 percent require COWPS approval.

Preliminary Economic Outlook for 1980

Economists generally agree that the recession will be more severe than previously forecast as a result of recent Federal Reserve action to halt inflation. Small businesses and industries connected with consumer spending are expected to be hardest hit by the tight money policy. However, exports,

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defense spending and capital spending on machine tools, farm equipment, transportation equipment, and oil and gas drilling are expected to increase in 1980. The rate of return on Plans' investment income is expected to be higher in 1980 than in 1979. Meanwhile, Plans' expenses will be higher due to increased utilization, which generally accompanies a recession, an acceleration in the rate of increase of medical care costs, and higher administrative expenses resulting from an easing of the wage standard.

Citibank's View of New York in 1980

The City's economy is smaller and better balanced than prior to the last recession. This should enable it to weather an economic downturn without a crisis. However, over the next 15 months, the City's population is expected to continue to shrink, employment to drop 1-2 percent, and unemployment to climb to 11-12 percent. Two sectors which are expected to register employment losses are manufacturing and municipal employment.

Has Volunteerism Worked? (One Congressional Committee's Response)

The VE is responsible for savings of $1.9 billion in the two year period 1978-1979, according to the Congressional Budget Office (CB)). However, the CBO does not believe that "volunteerism" is a long run solution to rising health care costs. Walter J. McNerney and other health care leaders vigorously disagree with this view.

Inflation Report

- Producer Price Index.
- Consumer Price Index.
- AHA Hospital Cost Index.
- AHA Hospital Intensity Index.
- AHA Real Service Volume Index.
- National Panel Survey.

"VOLUNTARY" WAGE AND PRICE STANDARDS FOR 1980

On September 28, 1979, President Carter announced that he would begin a second year of voluntary wage and price guidelines by appointing a Pay Advisory Committee, consisting of representatives from labor, business, and the public, and a Price Advisory Committee, consisting of 5 public members.

The labor representatives appointed to the Pay Committee are:

Lane Kirkland, secretary-treasurer of the AFL-CIO,
Douglas Fraser, president, United Auto Workers,
Frank Fitzsimmons, president, Teamsters union,
Lloyd McBride, president, United Steel Workers,
John Lyons, president, International Association of Bridge and Structural Iron Workers, and
William Wynn, president, United Food and Commercial Workers.

The business representatives are:

Phillip Hawley, president and chief executive officer of Carter Hawley Hale Stores,
Heath Larry, president, National Association of Manufacturers,
Jesse Hill, president and chief executive officer of Atlanta Life Insurance,
Charles McDonald, Chairman, Council of Smaller Enterprises and president, McDonald Equipment Company,
John T. Conner, chairman, Allied Chemical Corporation, and
Norma Pace, senior vice president, American Paper Institute.

The public representatives are:

John Dunlop, Harvard Business School professor,
Phyllis Wallace, MIT professor,
Robben Fleming, president, Corporation of Public Broadcasting,
Arvin Anderson, chairman, New York City office of collective bargaining,
Lloyd Ulman, University of California, and
Robert Nathan, economic consultant.

Wage standard

The Pay Committee, which will be chaired by former Labor Secretary John Dunlop, will set the wage standard to be used in the program year which began October 1, 1979. In addition, it will consider individual cases for exceptions to the wage guidelines.

The Committee's recommendations are due October 31st, 1979. In the interim, the present standard continues in effect. However, COMPANIES WHO ARE IN COMPLIANCE, AND WHOSE WORKERS ARE NOT COVERED BY A COLA CAUSE, MAY IMMEDIATELY INCREASE AVERAGE HOURLY WAGES BY 8 PERCENT. In addition, in extraordinary case, increases of more than 8 percent may be approved. However, employers seeking an increase in excess of the generally applicable standard must first

request approval from the Council on Wage and Price Stability (COWPS). The request for an exception to the wage standard must be fully documented and include information such as the increase in labor turnover that resulted from complying with the 7 percent standard and prevailing wage rates for comparable jobs in the community.

John Dunlop, the chairman of the Pay Committee, has called the 7 percent standard "asinine". He is on record as opposing inflexible guidelines. In view of the nature of Mr. Dunlop's experience (he has been deeply involved in every major incomes program since World War II) and his reputation among business and labor leaders for understanding the intricacies of pay and price restraint better than anyone else, it seems likely that the Committee will recommend a flexible standard.

Price standard

The Price Committee will deal with a second year price standard developed by COWPS. However, the new standard does not affect Plans. Since the price standard for health insurers runs on a calendar year basis, second year revisions will be proposed by COWPS later this year. Plans will have the opportunity to comment on the standard before it is finalized.

The physician fee standard is extended to the second year as a cumulative limitation by compounding 6.5 percent over 2 years. Thus, between October 2, 1978 and October 1, 1980, average physician fees may not exceed 13.4 percent.

HEW is responsible for developing and monitoring standards for non-federal hospitals. Hospital cost containment legislation is before Congress. That legislation sets guidelines for increases in hospital expenditures based on the inflation rate for hospital purchases, population growth, and intensity of service. It allows hospital expenditures to increase by about 12.9 percent in 1979. Voluntary guidelines for 1980 have not yet been computed.

Federal hospitals, like HMOs, are exempt from the price standard. However, they are subject to the wage standard.

Sanctions

Companies seeking government contracts must continue to certify compliance with the program. The National Accord between the Administration and labor is said to contain the Administration's promise not to use procurement sanctions. The Administration is interpreting this to mean as long as restraints are working.

PRELIMINARY ECONOMIC OUTLOOK FOR 1980

Economic data for the third quarter indicates that the economy was in better economic health and inflation higher than originally expected. For example, third quarter real GNP was positive, rather than negative, unemployment fell in September, instead of rising, and the producer price index jumped at an annual rate of almost 17 percent in September, the largest monthly increase in 5 years. In addition, speculative fever hit the commodity and financial markets. The price of gold and other precious metals soared, while the value of the U.S. dollar on foreign markets declined.

These events caused the Federal Reserve to announce an anti-inflation program. The program basically raised the cost of capital and shifted the focus of monetary policy to the supply of money rather than interest rates. Interest rates will be more volatile and should continue to rise until the end of the year. Money may become more difficult, if not impossible, for some to borrow. Economists agree that the impact of this program will be to intensify the recession and increase unemployment.

Impact on Plans

Over the next 15 months Plans' income will be affected by declining employment, a reluctance on the part of some companies experiencing a reduction in profits to add health benefits, and continued restraints on rate increases. Some money analysts are predicting that average annual interest rates in 1980 will be higher than in 1979. Accordingly, Plans' investment income for 1980 should be higher than in 1979.

Meanwhile, Plans' expenses will be affected by increases in utilization due to increasing births and surgery, rising medical care costs, and higher administrative expenses resulting from an increase in the wage standard. (See article in this issue.) A reduction in corporate cash flow resulting from the decline in business activity, tightening of credit and high interest rates will intensify the pressure on Plans to provide alternative financial arrangements.

a. Income

Employment is expected to decline in 1980. This is in sharp contrast to the growth in employment, particularly in manufactures of durables, construction, and services, which occurred between 1977 and the first quarter of 1979. The decline in employment over the coming months will affect Plan enrollment.

Small businesses, which are responsible for approximately 60 percent of additions to the labor force, will generally be hurt more than the large corporations by the tightening of credit and high interest rates, and probably will not be adding workers.

Industries expected to be hardest hit by the tighter monetary policy are those connected with consumer spending, e.g., housing and consumer durables. However, analysts are predicting that the auto and truck sales rates have already experienced much of their cyclical decline. Employment in the Government sector will continue to show no growth due to budget austerity.

Some economists expect capital spending on machine tools, farm equipment, transportation equipment, and oil and gas drilling to increase in 1980. Real spending on defense is expected to reverse its current trend and increase 1-4 1/2 percent per annum throughout the 1980s. The slowing of economic activity is expected to reduce inflation, strengthen the U.S. dollar, and boost exports.

Companies experiencing a reduction in profits as economic activity slackens may be reluctant to increase unit labor costs by adding new benefits, e.g., dental and vision care, particularly if they expect that such costs (premiums) will increase sharply in the following year. An increase in unemployment may also cause some companies to believe that it is not necessary to improve employee morale or attract new workers with improved benefit packages. In addition, some small companies, whose earnings cannot support the present high cost of borrowing (18-19 percent plus compensating balances) may seek to modify their benefit package and make greater use of copayments and deductibles.

Inflation of 9-10 percent is predicted for 1980. This is in contrast to 13 percent currently predicted for 1979. The 1980 inflation forecast is substantially above previous post recession rates, and if realized will continue to pose economic and political problems for the Administration. Later this year the Administration will probably propose a price standard for health insurers for CY 1980 which continues to restrain premium increases through deceleration of inflation trend factors.

The rate of return on Plans' investment income will be higher in 1980 than in 1979. In October, the Federal Reserve boosted the discount rate (the rate the Fed charges on loans to its member banks), increased some reserve requirements, and shifted the focus of monetary policy to controlling bank reserves rather than interest rates. This move was designed to curtail the rapid expansion of credit, strengthen the dollar, and halt speculation. Bankers and economists are expecting a further rise in interest rates as a result of these restrictive measures. The prime, or minimum, lending, rate is currently 14 1/2 percent. Some economists are predicting that it will go to 16 percent by year end. However, as 1980 unfolds, economic activity slackens, and loan demand falls off, interest rates are expected to fall. Some analysts are predicting that the prime will return to 13 percent by the latter part of 1980.

b. Expenses

Plans' expenses are affected by changes in utilization, claim costs, and administrative expenses. Recessions generally increase utilization as some laid-off workers utilize health benefits before they expire. Economists are predicting that unemployment will reach 8-9 percent by the end of 1980, in contrast to 5.8 percent in September 1979. Moreover, since lay-offs are generally based on seniority, and new workers will have difficulty obtaining jobs, the work force will consist of older workers, who generally utilize health benefits more intensely than a younger work force.

Some economists are predicting that a recession will increase the birth rate. These economists believe that as female unemployment rises, a family will no longer have to forego the wife's salary to have a baby. This decreases the cost of having a child, and could increase the birth rate.

Health economists are predicting that not only will hospital expenses be higher in 1980 than in 1979 due to increases in labor, nonlabor, and interest costs, but the decelerating rate of increase in health care costs, which dates from 1975, will be reversed. The increase in labor costs will be caused by the increase in the minimum wage and the wage standard, while the increases in the price of some nonlabor inputs, such as energy and food, are likely to affect hospitals belatedly.

Plans' administrative expenses will probably be higher in the coming year. The wage standard for the program year beginning October 1, 1979 has been eased. Plans complying with the 7 percent wage standard and whose workers are not covered by COLA clauses may unilaterally increase employee wages by 8 percent. In extraordinary cases, larger wage increases may be granted. However Plans who seek extraordinary increases must first seek approval from the Council on Wage and Price Stability (COWPS).

Summary

Over the next 15 months, the combination of increased medical costs and decreased premium income could put pressure on Plans reserves. However, this pressure is likely to be eased by increases in Plans investment income.

****

CITIBANK'S VIEW OF NEW YORK IN 1980

On the brink of a business slowdown, New York City's economy is smaller and better balanced than prior to the last recession. No major sector is so obviously out of line as was the case with municipal government in the late 1960s through 1976; the financial sector in 1967-69; and real estate space in 1972-75. This should enable the City to weather an economic slowdown without a crisis, according to Citibank's Monthly Economic Letter.

The City's general economic health has improved steadily since 1975, both absolutely and relative to earlier trends. On the brink of the current downturn, employment in the City is up, unemployment is down, construction has picked up, and retail sales, adjusted for inflation, have increased 6 percent during the past year. Receipts from municipal taxes have been higher than anticipated.

However, Citibank predicts that the economic slowdown will not leave the City unscathed. Employment will drop 1-2 percent in 1980, in contrast to the modest increase that occurred between 1977 and the first quarter of 1979. Unemployment will climb to 11 - 12 percent, from 9.2 percent in August, 1979. Two sectors which are expected to register employment losses are manufacturing and municipal employment. Retail sales are expected to be weaker.

Manhattan's economic base is shifting from manufacturing to white collar employment. Citibank predicts that in the 1980's the outer boroughs will play a relatively more important role in providing the manufacturing employment that remains in the City.

The article concludes that the City has somewhat farther to go in the shrinkage in employment and polulation, and that many of the pluses of 1977-78 will have disappeared by 1980. However, the underlying currents will provide better economic support in the 1980s than was the case over much of the 1970s.

HAS VOLUNTEERISM WORKED?
(One Congressional Committee's response)

The answer is "yes", the Voluntary Effort (VE) has made a significant contribution to containing health care costs, according to a report recently issued by the Congressional Budget Office (CBO). In 1978, hospital expenditures increased by 12.8 percent, or 1.1 percentage point less than CBOs estimate of the most probable increase in hospital expenditures without the VE. CBO estimated that savings due to the VE in 1978 were $0.6 billion, of which $0.2 billion represents Federal Medicare and Medicaid savings. (See Table 1.) Furthermore, it predicts that based upon first quarter data, 1979 hospital expenditures will increase 14.5 percent, instead of 15.6 percent, which would have occurred in the absence of the VE. Savings attributed to the VE in 1979 are $1.3 billion, of which $0.5 billion represents Federal Medicare and Medicaid savings. The CBOs report states that these savings resulted from increased efficiency rather than a deterioration in the quality of hospital care.

However, the CBO does not believe that the VE is a viable long term solution to rising health care costs because voluntary efforts to contain costs are in conflict with self interest. CBO believes that if the threat of mandatory controls on hospital expenditures were removed, voluntary efforts on the part of physicians, hospitals, and third party payors to contain costs would be substantially reduced.

Leaders of the health care sector vigorously disagree with this view. Walter J. McNerney, President of the Blue Cross and Blue Shield Associations, in his address to the AHA annual meeting in August, stated that volunteerism, of which the VE is the prime example, is basic to, and an inherent part of, the functioning of the health care sector. He believes that private sector voluntary initiatives to achieve a more cost effective health care delivery system will continue to play an important role in the functioning of the health care sector whether or not there are hospital cost caps.

TABLE 1: EFFECT OF THE VOLUNTARY EFFORT (VE) ON RATES OF INCREASE IN HOSPITAL EXPENDITURES, 1977 - 1979

	Rate of Increase Over Previous Year (percent)			Percent Reduction in Level of Hospital Expenditures	Savings (in billions of dollars)	
Year	VE Goal	Actual	Expected If No VE	Due to VE	Total	Federal
1977	--	15.6[a]	--	--		
1978	13.6	12.8[a]	13.9[b]	0.9	0.6	0.2
1979	11.6	14.5[b]	15.6[b]	1.9	1.3	0.5

a. Actual expenditure data from American Hospital Association, National Hospital Panel Survey.
b. CBO forecast.

SOURCE: Congressional Budget Office, Congress of the United States; "Controlling Rising Hospital Costs", September, 1979.

INFLATION REPORT

General price report

The slackening of economic activity has not yet resulted in a slowing of inflation. Prices of goods and services continue to increase at double digit rates and provide the impetus for further inflation. Many Congressmen, generally critical of a tight monetary policy, muted their criticism of the Federal Reserve's recent actions because inflation was getting out of control.

In September, the producer price index of finished goods increased 1.4 percent, seasonally adjusted, the highest monthly increase in five years. This followed a 1.2 percent increase in August, and a 1.1 percent increase in July. Food and energy prices, which were largely responsible for the jump in the September index, will be passed on to consumers, and reflected in the CPI in the months ahead.

In August, the consumer price index for all urban consumers (CPI-U), which covers approximately 80 percent of the civilian population, increased 1.0 percent, unadjusted. This was the seventh consecutive month in which consumer prices increased by at least 1.0 percent. Energy and housing costs continued to increase sharply.

CPI-U index of medical care prices

In August, the CPI-U index of medical care prices continued to increase at a slower rate than inflation.

TABLE 2: PERCENT CHANGE IN THE CPI-U
ALL U.S. CITIES, UNADJUSTED

	AUGUST 1979 to	
	JULY 1979	AUGUST 1978
All items	1.0	11.8
Food and beverage	- 0.2	9.6
Housing	1.4	12.8
Energy	3.2	32.5
Medical care	0.9	9.2

Source: Bureau of Labor Statistics

Prices of medical services also increased at a slower rate than the price of other services.

TABLE 3: PERCENT CHANGE IN CPI-U
ALL U.S. CITIES, UNADJUSTED

	AUGUST 1979 to	
	JULY 1979	AUGUST 1978
Services less medical care	0.8	11.6
Medical care services	0.8	9.6
Physician services	0.8	9.6
Dental services	0.4	8.1

Source: Bureau of Labor Statistics

The VE appears to be successful in containing hospital costs. For the second consecutive month, the price of a hospital room increased at a slower rate than the all items index for a 12 month period.

TABLE 4: PERCENT CHANGE IN CPI-U
ALL U.S. CITIES, UNADJUSTED

	AUGUST 1979 to	
	JULY 1979	AUGUST 1978
All items	1.0	11.8
Hospital room	1.0	11.0
Hospital and other medical care services	0.9	10.7

Source: Bureau of Labor Statistics

Other indicators of changes in hospital costs

The AHA publishes the Hospital Cost Index (HCI), which reflects changes in the price of a fixed hospital market basket consisting of 46 procedures. It also publishes a hospital intensity index (HII), which reflects changes in the quantity of these same procedures. The real service volume index (RSV) adjusts the intensity index (HII) for changes in adjusted patient days, seasonally adjusted. Data for these indexes is collected from approximately 700 hospitals. In the latest 12 month period for which information is available, July 1978 to July 1979, the HCI, the HII, and the RSV increased 11.0 percent, 1.4 percent, and 3.9 percent, respectively.

The AHA also publishes information on changes in hospital expenses and utilization from the National Panel Survey, a monthly survey of 1,760 community hospitals representing a cross section of the industry. Hospital expenses increased 13.9 percent for the latest 12 month period ending July 1979, in contrast to a 12.8 percent increase for the 12 month period ending July 1978. The year to date increase in hospital expenses was 13.3 percent. Prices of hospital supplies and services caused nonlabor expenses to grow 15.5 percent for the month. Labor related expenses, including wage and fringe benefits, were up 9.6 percent for the year ending July 1979 for the average employee.

The National Panel Survey reported that utilization continued to rise in July as a result of increases in surgical operations and births. The increase in surgeries occurred primarily in the under-65 population. The rate of increase in surgeries accelerated in the Northeast and the North Central States. Increases were also experienced in the Southwest. Fears of an impending recession and lay-offs, a shortening of the workweek, as well as a decline in the cost of medical care relative to other goods and services may have encouraged some workers to increase their consumption of health care.

TABLE 5: PERCENT CHANGE IN HOSPITAL EXPENSES AND UTILIZATION

	JULY 1979 to JULY 1978	JULY 1978 to JULY 1977
Hospital expenses	13.9	12.8
Admissions	4.6	1.8
Adjusted patient days	2.5	1.4
Out patient visits	- 0.5	2.7
Surgical operations	8.2	0.4
Births	4.6	0.4

Source: AHA. National Panel Survey.

Figure I

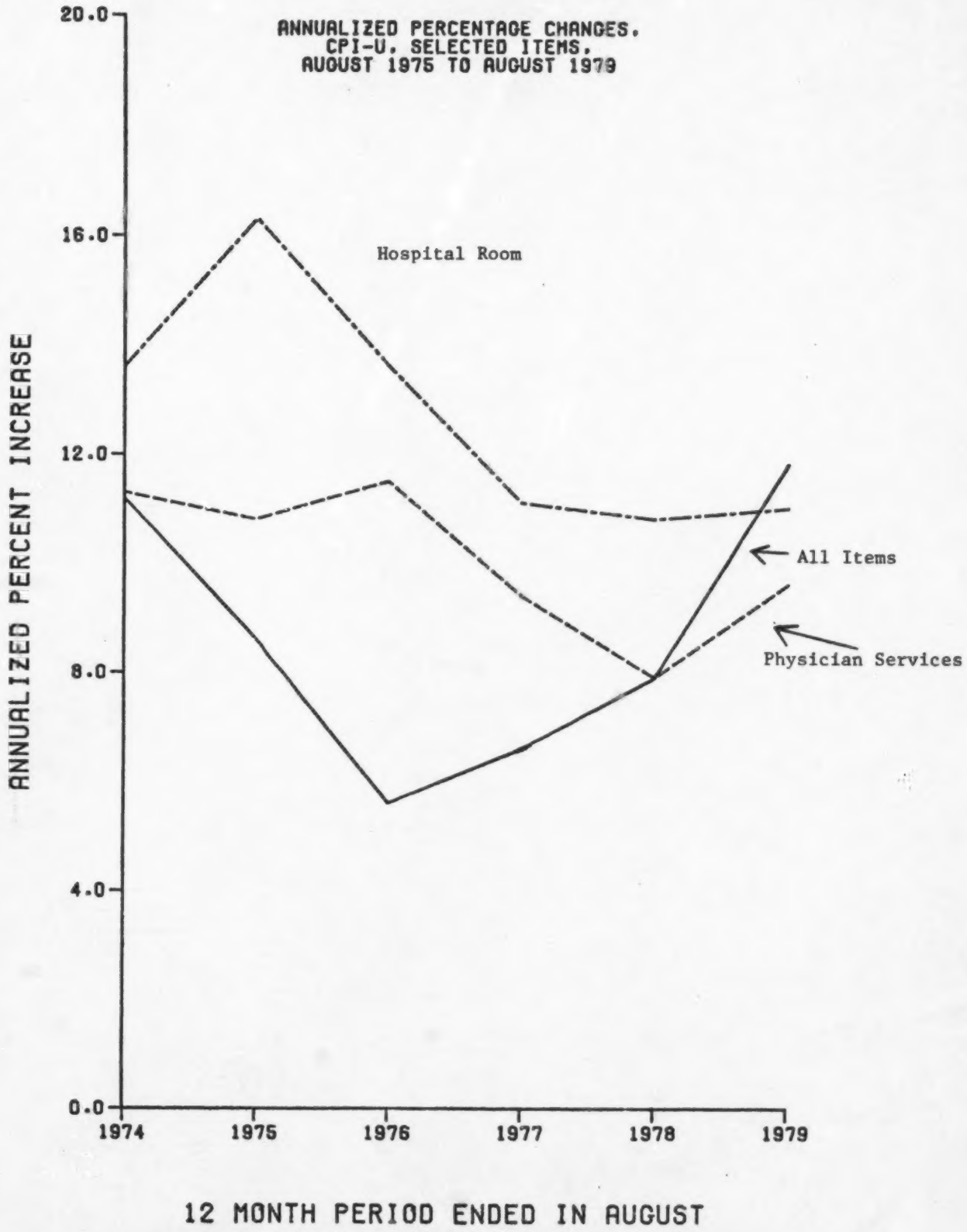
ANNUALIZED PERCENTAGE CHANGES.
CPI-U, SELECTED ITEMS.
AUGUST 1975 TO AUGUST 1979
20.0
16.0
12.0
8.0
4.0
0.0
ANNUALIZED PERCENT INCREASE
Hospital Room
All Items
Physician Services
1974
1975
1976
1977
1978
1979
12 MONTH PERIOD ENDED IN AUGUST

Figure II

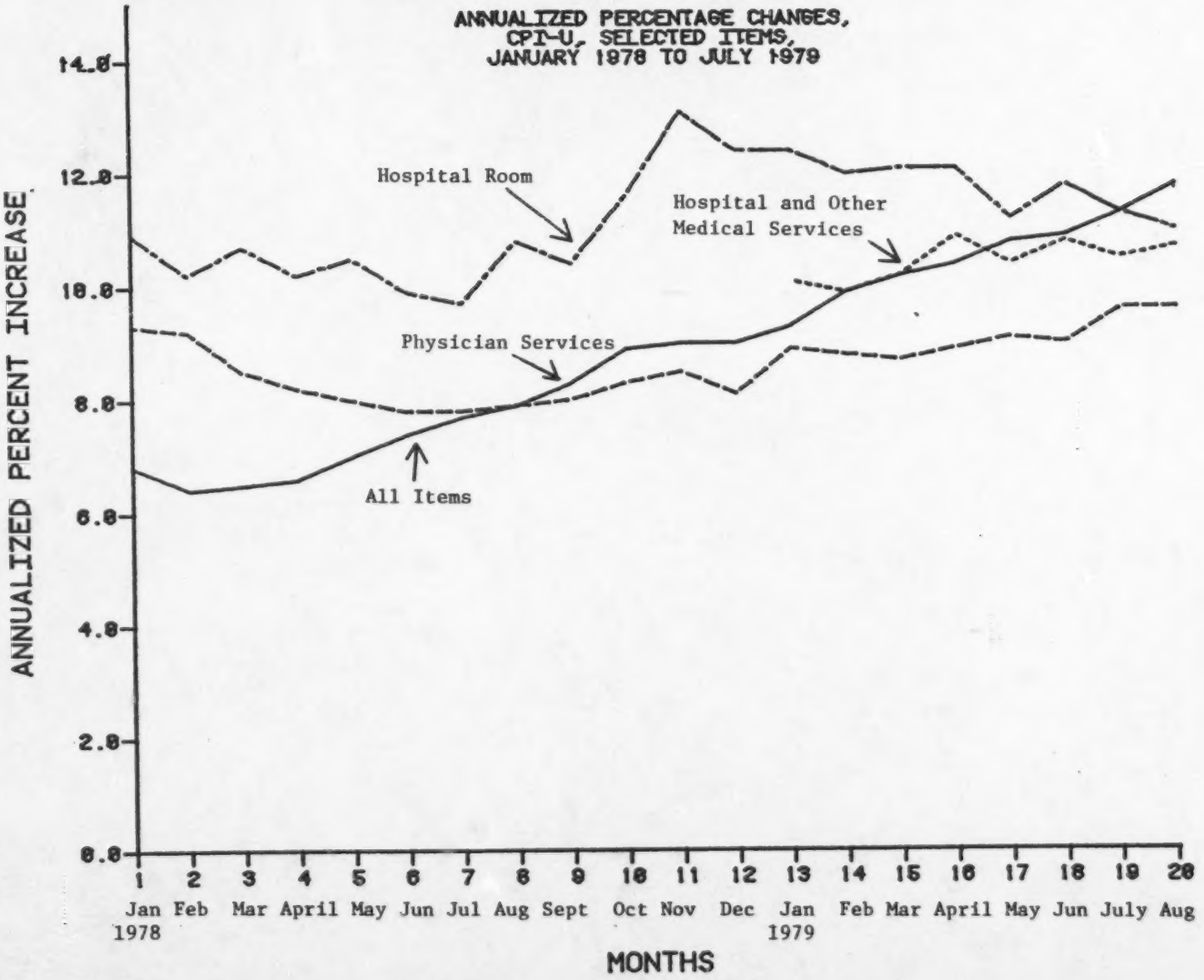
ANNUALIZED PERCENTAGE CHANGES,
CPI-U, SELECTED ITEMS,
JANUARY 1978 TO JULY 1979
ANNUALIZED PERCENT INCREASE
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Hospital Room
Hospital and Other
Medical Services
Physician Services
All Items
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Jan Feb Mar April May Jun Jul Aug Sept Oct Nov Dec Jan Feb Mar April May Jun July Aug
1978
1979
MONTHS

Figure III

ANNUALIZED PERCENTAGE CHANGES,
Hospital Cost Index, Hospital Intensity Index, Real Service Volume
January 1978 to July 1979

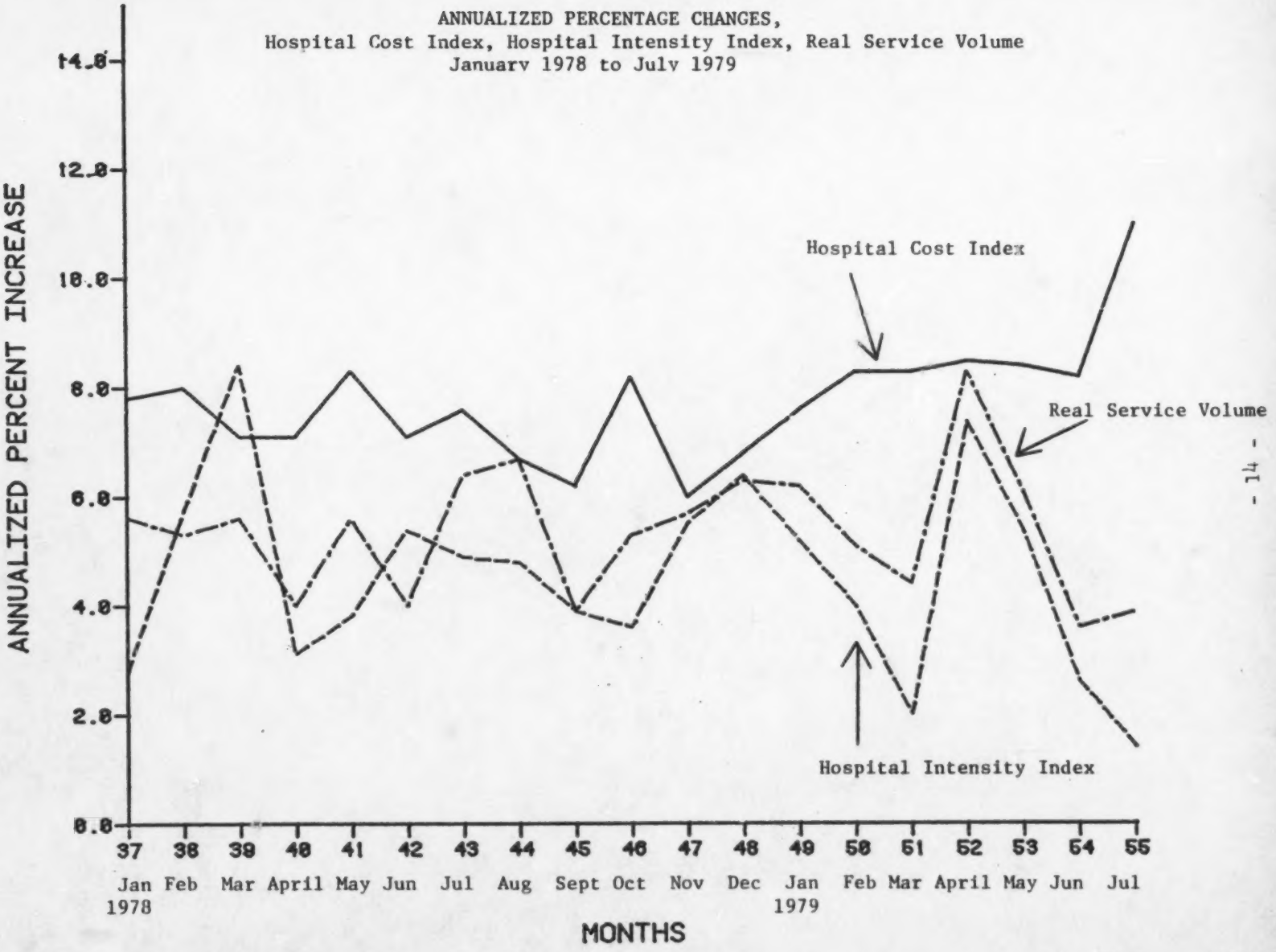

Table 6

Monthly Percentage Increase for the Consumer Price Index for All Urban Consumers (CPI-U), Selected Items, All U.S. Cities (Unadjusted)

EXPENDITURE CATEGORY	1978		1979								August 1978-August 1979
	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July	August	12 month
All Items	0.6	0.9	0.9	1.2	1.0	1.1	1.2	1.2	1.1	1.0	11.8
Medical Care	1.0	0.4	1.3	0.8	0.6	0.5	0.5	0.6	0.9	0.8	9.2
Medical Care Commodities	0.8	0.7	0.5	0.9	0.4	0.6	0.5	0.6	0.5	0.6	7.3
Medical Care Services	0.8	0.5	1.4	0.8	0.6	0.5	0.5	0.6	1.0	0.8	9.6
Professional Services	0.8	0.2	1.5	0.7	0.5	0.5	0.6	0.6	0.8	0.6	8.7
Physician Services	0.7	0.3	1.6	0.7	0.5	0.7	0.7	0.5	1.2	0.8	9.6
Dentist Services	0.6	0.8	1.6	0.7	0.4	0.5	0.5	0.9	0.4	0.4	8.1
Other Professional Services	0.4	0.3	1.0	0.5	0.1	0.5	0.7	0.4	0.8	0.4	7.2
Other Medical Care Services	1.3	0.4	1.4	0.5	0.6	0.5	0.4	0.6	1.1	1.1	10.5
Hospital and Other Medical Care Services	1.2	0.5	1.3	1.0	0.8	0.4	0.3	0.5	0.9	1.1	10.2
Hospital Room	1.3	0.5	1.5	1.0	0.6	0.3	0.4	0.6	1.0	1.2	11.0
Other Hospital and Medical Care Services	0.6	0.9	1.1	1.1	0.6	0.5	0.2	0.4	1.0	0.9	9.5
Services	0.5	0.4	0.9	1.0	0.8	0.8	1.1	1.1	1.1	1.2	11.3
Services, Less Medical Care	0.5	0.3	0.8	1.0	0.8	0.9	1.2	1.2	1.1	0.8	11.6

Source: Bureau of Labor Statistics

Table 7

Monthly Percentage Increase for the Consumer
Price Index for Urban Wage Earners and Clerical Workers (CPI-W),
Selected Items, All U.S. Cities
(Unadjusted)

EXPENDITURES CATEGORY	1978		1979								August 1978-August 1979
	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July	August	12 month
All Items	0.5	0.5	0.9	1.2	1.1	1.2	1.2	1.2	1.2	1.0	12.0
Medical Care	0.8	0.5	1.0	0.8	0.7	0.6	0.5	0.8	1.0	0.9	9.6
Medical Care Commodities	0.7	0.7	0.6	0.7	0.7	0.5	0.5	0.8	0.5	0.6	7.7
Medical Care Services	0.8	0.5	1.1	0.9	0.7	0.6	0.4	0.8	1.1	0.9	10.0
Professional Services	0.7	0.3	1.2	0.7	0.8	0.7	0.5	0.9	0.9	0.8	9.7
Physicians Services	0.7	0.3	1.1	1.1	0.8	0.8	0.6	0.9	1.3	0.8	10.4
Dentist Services	0.6	0.8	1.1	0.6	0.6	0.7	0.4	0.9	0.3	0.9	9.3
Other Professional Services	0.4	0.3	1.0	n/c	1.1	0.3	0.3	0.5	0.9	0.5	7.3
Other Medical Care Services	1.1	0.4	1.0	1.0	0.7	0.6	0.4	0.8	1.3	1.1	10.4
Hospital and Other Medical Care Services	1.2	0.5	1.0	1.0	0.4	0.5	0.3	0.5	1.1	1.0	9.7
Hospital Room	1.3	0.5	1.1	0.8	0.5	0.5	0.3	0.4	1.3	1.1	10.5
Other Hospital and Medical Care Services	1.1	0.4	1.1	1.1	0.4	0.6	0.3	0.5	1.1	1.0	9.2
Services	0.5	0.4	0.9	1.0	0.9	0.9	1.1	1.1	1.2	1.2	11.6
Services, Less Medical Care	0.5	0.3	0.9	1.0	0.8	1.0	1.2	1.2	1.2	1.3	11.7

Source: Bureau of Labor Statistics

TABLE 8

Percent Changes in CPI-U,
Selected Items, all U.S. Cities
(Unadjusted)

	Compound Annual Rate, 8 months ended August 1978	Compound Annual Rate, 8 months ended August 1979
All Items	9.6	13.6
Medical Care	8.8	9.4
Medical Care Commodities	7.3	7.2
Medical Care Services	9.2	9.8
Professional Services	7.2	9.2
Physician Services	8.2	10.3
Dental Services	7.8	8.4
Other Professional Services	6.7	6.6
Other Medical Care Services	10.6	10.5
Hospital and Other Medical Care Services	11.6	10.0
Hospital Room	12.4	10.3
Other Hospital and Medical Care Services	10.9	9.7
Services	9.8	12.9
Services, Less Medical Care	9.8	13.3

TABLE 9

Percent Changes in CPI-W
Selected Items, all U.S. Cities
(Unadjusted)

All Items	9.6	14.1
Medical Care	8.7	9.8
Medical Care Commodities	7.8	7.7
Medical Care Services	9.0	10.2
Professional Services	7.7	10.1
Physician Services	8.4	11.8
Dental Services	7.5	8.5
Other Professional Services	5.9	7.1
Other Medical Care Services	10.2	10.4
Hospital and Other Medical Care Services	11.3	9.2
Hospital Room	12.0	9.4
Other Hospital and Medical Care Services	10.5	9.1
Services	9.6	13.1
Services, Less Medical Care	9.6	13.6

Source: Bureau of Labor Statistics

TABLE 10

12 Month (August -to- August) Percentage Change
in CPI-U, Selected Items, U.S. Cities, Unadjusted

	Aug. 1973- Aug. 1974	Aug. 1974- Aug. 1975	Aug. 1975- Aug. 1976	Aug. 1976- Aug. 1977	Aug. 1977- Aug. 1978	Aug. 1978- Aug. 1979
All Items	11.2	8.6	5.6	6.6	7.9	11.8
Medical Care	11.7	11.2	9.3	9.7	8.1	9.2
Medical Services	12.8	11.6	9.7	10.1	8.2	9.6
Physician Services	11.3	10.8	11.5	9.4	7.9	9.6
Dental Services	9.4	9.4	6.1	8.0	6.7	8.1
Hospital Room	13.6	16.3	13.6	11.1	10.8	11.0
Services	10.7	8.6	8.6	8.0	8.7	11.3
Services, Less Medical Care	10.3	8.0	8.4	7.6	8.8	11.1

Source: Bureau of Labor Statistics

A3560-1

Blue Cross
Association
Blue Shield
Association

840 North Lake Shore Drive
Chicago, Illinois 60611
312/440-6000

November/December 1979

TO: Chief Plan Executives

FROM: Edward S. Mills, Vice President, Health Economics Research

SUBJECT: Economic Report

IN THIS ISSUE

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  - Labor force
  - Birth rate
  - Family patterns
  - Age of population
  - Implications for Plans
- Economists Forecast Recession in 1980
  - Economic forecasts of several notable private forecasting organizations
  - Impact on Plans
- Status of Second Year Price and Pay Standard
  - Price
  - Pay
- Impact of Recession on New England
- Impact of Recession on New York

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Commemorating fifty years
Working for a healthier America

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  - Criticism of CPI
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    - AHA Hospital Cost Index
    - AHA Hospital Intensity Index
    - AHA Real Service Volume
    - AHA National Panel Survey

CHANGING DEMOGRAPHIC PATTERNS AND THEIR PROBABLE IMPACT ON PLANS

Introduction

Plan actuaries and underwriters, as well as those responsible for marketing and corporate planning, are finding it useful to keep abreast of changes in demographic patterns in order to estimate revenue and claim costs, as well as to identify potential markets. The following article describes expected changes in the labor force, birth rate, family patterns and age of the population in the 1980s, and discusses some of the implications of these events on Plans' activities.

Labor Force

a. 1970s

The labor force increased at a very rapid rate during the 1970s, especially since the 1974-75 recession. This is attributable to the entrance into the labor force of the members of the 1946-64 baby boom and an increasing number of females and teen-agers who have obtained (or tried to obtain) employment. The increase in demand by consumers, business, and government since the last recession led to the creation of approximately 12 million new positions, of which 58 percent were filled by women.

More women entered or reentered the labor force in the 1970s than in any other decade. Most of this increase represented women under age 35. Prior to the 1970s, the distribution of women in the labor force was bimodal. The peaks represented ages 16 - 24, and over 35, with a sharp valley between, representing ages 25 - 34. However, during the 1970s, the labor force participation rate (the percentage of persons within specified groups who are members of the labor force) for women ages 25 - 34 advanced by 17 percentage points, reaching 62 percent in 1978. This is remarkable since more than 70 percent of women in this age group are married, live with their husbands, and have children under the age of 18. By 1978, about 16.1 million women in the labor force had children under the age of 18, and of these, about 5.8 million had children under the age of 6. The labor force participation rate for women with preschool children was 44 percent in 1978, compared with only 30 percent in 1970. More than 50 percent of women in the labor force in 1978 had children between the ages of 6 and 18.

The Bureau of Labor Statistics (BLS) estimates that approximately one-half of husband-wife families currently have at least two wage earners, and about 40 percent of children under 18 live in multiple wage earner households. Data from the Current Population Series show that between 1960 and 1977 nearly 60 percent of the total net increase in the number of working wives consisted of wives whose husbands had incomes in the upper middle and upper ranges (in 1976, $15,000 or more).

b. 1980s

The annual rate of growth of the labor force is expected to decrease to 1.8 percent over the next 10 years, in contrast to the current 2.4 percent rate. This decline in the growth rate has led to predictions of a labor shortage beginning in the mid-1980s.

The share of teen-agers in the labor force is expected to decline during the 1980s as a result of their shrinking share of the population. The BLS estimates that by 1990 the number of people in the labor force aged 16 - 24 will have declined by about 16 percent and the portion of the total labor force which will be made up of this group will have fallen from 24 percent to 18 percent.

The bulk of the labor force will be between ages 25 - 44. The number of job holders and job seekers in this age group will jump by one-third from 1980 (by 50 percent from 1975), so that by 1990 they will constitute about 53 percent of the total work force.

The number of people aged 55 and over will continue to rise from approximately 44 million in 1980 to 48 million in 1990. The BLS predicts that this group's share of the labor force will fall slightly, from 14 percent in 1980 to 12 percent in 1990. However, modification of social security regulations, continued inflation, and the elimination of compulsory retirement could induce older workers to remain in the labor force. Many large companies have reported that since the enactment of the Age Discrimination in Employment Act (ADEA), which eliminates mandatory retirement before age 70, many workers eligible for retirement at age 65 have not retired. The predicted labor shortage also makes employees who would have normally retired from the labor force a prime source of supplementary labor supply.

The BLS has predicted that the female participation rates (the number of females age 16 and over who are members of the labor force divided by total females age 16 and over) will increase from slightly over 50 percent today, to 57 percent in 1985, and 60 percent in 1990. Data Resources estimates that about 65 percent of all new jobs created through 1985 will be filled by women. In addition, in the 1980s, there will be more children with working mothers. This growth will be especially pronounced among children under age 6 because of the expected increased in the total number of children and because more of their mothers are expected to be employed. If current BLS forecasts are accurate, between 1978 and 1990, the percentage of children under age 6 with working mothers will rise by 50 percent, while the total number of preschool children will increase by about 37 percent.

The male participation rate, which trended downward from 80 percent in 1970 to 78 percent in 1977, is expected to regain the rate of the early 1970s by 1985, and to slightly exceed that rate in 1990.

The greatest growth in employment is expected to occur in the South and West, areas most accessible to immigration. During the 1970s, workers emigrated from the North East and North Central states to the South and West, reversing the pattern of the past, and leaving some states with a net drop in population. Large cities, such as New York, Chicago, Philadelphia, Baltimore and Detroit lost workers, while Houston, Dallas, San Diego, and San Antonio gained workers. A recent issue of Sales and Marketing Management predicts that the fastest growing metropolitan areas in the U.S. in the next four years will be the Ft. Meyers-Cape Coral area of Florida, the Richland-Pasco-Kennewick region of Washington, and the Brownsville-Harlingen-San Benito area of Texas. Chase Econometrics

predicts that Oklahoma will attract so many new residents interested in jobs spurred by oil development, that the population will hit 3.3 million in 1990, 10 percent more than current Census Bureau estimates. Chase also predicts that Minnesota should begin to gain residents because of an increase in manufacturing and farm income. However, Chase predicts that the net outflow of population from Minnesota will resume in 1986, although the state's population will continue to grow because of a higher birth rate. Chase also predicts that Iowa will start attracting out-of-staters by 1982. The Census Bureau predicts that between 1980 and 2000, the fastest growing states will be Arizona, Florida, Nevada, Alaska, and Colorado, while the slowest growing states will be Ohio, Pennsylvania, and Illinois. Only New York and the District of Columbia will lose population.

Births

The baby boom occurred between 1946 and 1964. In those years, 76.4 million babies were born in the United States. For each of 11 consecutive years, 1954-1964, there were more than 4 million births.

Today there are approximately 70 million of the boom babies still alive. They are between 15 and 33 years of age and account for approximately one-third of the country's total population. During the 1980s, the majority of the baby boom population is expected to marry and have children. Some demographers are predicting a mini-baby boom in the 1980s. (See discussion below.) This should have a positive impact on business and housing.

Table 1

BABY BOOM AT A GLANCE

Began: 1946 Ended: 1964

Total births: 76,441,000

Peak Year: 1957 (4,332,000 births)

Years with greater than 4 million births: 1954-1964

Event	Boom Years	Peak
Birth	1946-1964	1957
Age 18, enter college or work	1964-1982	1975
Age 30, homeowners, families, births	1976-1994	1987
Age 50, earnings near peak	1996-2014	2007
Age 65, retirement	2011-2029	2022

Source: American Demographics, "A Changing America," 1979, p.11.

Between 1965 and 1976, the birth rate plummetted from 19.4 to 14.7 per 1,000 population. Since 1977, the birth rate has increased. (In July 1979, the latest month for which information is available, it was 16.4 per 1,000.) More liberal employee maternity benefits, improved methods of curing infertility, as well as an increase in the number of births among women in their 30s who postponed having their first child and feel it is now or never have contributed to the upturn in the birthrate.

Some economists, such as Richard Easterlin and Michael Wachter of the University of Pennyslvania, predict that the number of children per family will continue to rise throughout the 1980s and climb to an average of 2.7 births per woman from the present average of 1.9.

Easterlin and Wachter believe that as the small number of people born in the late 1960s and the 1970s come of age and enter the labor force, they will enjoy a competitive advantage and thus brighter economic prospects.* They predict that this group will marry at an earlier age and have more children. The empirical evidence for this is the relationship between the number of births in a given period and the fertility rate of that group. The smaller cohorts (those born in the same year) of the 1930s exhibited high fertility in the 1950s, whereas those born during the baby boom of the 1950s exhibited low fertility in the 1970s.

However, other economists, such as Charles Westoff of Princeton, predict birth rates of approximately 1.7 per woman. These predictions are based upon historical trends, improvement in birth control technology, and changing family patterns, including the postponement of marriage and the changing role and status of women in our society.

Gary Becker of the University of Chicago believes that the birth rate is countercyclical. He predicts that today's much smaller number of cohorts will not produce large numbers of cohorts in the 1980s because in the 1980s women's wages will increase absolutely and in relation to those of men, and that women will be reluctant to sacrifice income by staying home to raise children. The number of children a couple decide to have depends on the cost of each child, according to Becker. A major cost of child rearing is the time parents must spend on it, and the more the parents earn the more children "cost". Thus, while parents with rising incomes could apparently afford more children, they will have fewer children invest more money in each child.

However, Becker and Westoff believe that fertility rates will probably become more volatile and responsive to short-term economic fluctuations in the years ahead. An increase in female unemployment could result in an increase in the birth rate as the wife no longer has to forego income to have a baby. They recognize that perfect control over the timing of births does not necessarily mean that couples will not want more than one or two children. However, they believe that the trend is toward fewer children.

Family Patterns

The rate of increase of households is greater than the corresponding figure for the population. Between 1970 and 1979, the number of households increased by approximately 22 percent, and the population by 8 percent. Demographers are predicting that in the next ten years the population will increase by about 10 percent and the number of households will increase by 21 percent. The increase in the number of households in the 1980s means that the demand for goods and services oriented to the home will increase at a faster rate than those consumed by individuals.

---

*Competition to move up the organizational ladder is expected to be intense for workers in the age bracket 24 - 55 in the 1980s. For example, in 1975, there were approximately 10 workers competiting for a middle management job. In the 1980s, that number is expected to increase to 13, of which approximately 3 will be women and 3 other minority groups.

Meanwhile, household size is expected to continue to decline. The average number of persons per household was 3.14 in 1970 and 2.78 in 1979. Demographers are predicting that average household size will fall to 2.4 by the end of the 1980s.

Not only are there fewer children per household as a result of declining fertility, but there are also fewer adults. This is largely a result of delayed marriage and divorce. For the first time in history, more than 50 percent of U.S. households consist of one or two people. Data Resources estimates that about one-third of households will be headed by a single person in 1985. Most single adult households are headed by women.

The rapid rise in the divorce rate has led to an increase in single parent households. In 1978, nearly 50 percent more children were living with only one parent than in 1970.

SOME FACTS ABOUT THE AMERICAN HOUSEHOLD

* Only 17 percent of American households include a father who is the sole wage earner, a mother who is a full time mother, and one or more children at home.

* 23 percent of American households consist of both a father and a mother who are wage-earners, with one or more children at home.

* 32.4 percent of American households consist of married couples with no children, or none living at home.

* 6.6 percent of American households are headed by women who are single parents with one or more children at home.

* 0.7 percent of American households are headed by men who are single parents with one or more children at home.

Source: Chicago Tribune, Sunday, October 2, 1979, Section 12, p. 1.

Age of Population

The average age of the U.S. population is rising (the median age is already over 30) as a result of the baby boom generation arriving at adulthood, declining fertility rates, and a dramatic increase in longevity. See Table 2 for changes in the distribution of the population. In the 1960s, one year was added to the expected life span at birth, and in the 1970s, two years were added. During the 1960s, the death rate for the total population declined by less than one percent, but during the 1970s it declined by more than 5 percent. Life expectancy at birth is now more than 69 years for men and 77 years for women.

The aging of the population is also expected to continue to bring fundamental changes in society's view about "old" people. Enterprising businesses will promote activities for the over-70 generation. Gerber Products has started selling life insurance with the motto, "Gerber now babies the over-50s" and Wrigley (the gum company) has started making "stick-proof Freedent for the denture set".

Table 2

THE PAST - AND SOME FORECASTS

	1975	1980	1985	1990
U.S. Population (Mil.)	213.6	222.2	232.9	243.5
Persons by Age	100.0%	100.0%	100.0%	100.0%
Under 18	31.0	27.9	26.7	26.6
18-24	12.9	13.3	12.0	10.3
25-34	14.5	16.3	17.1	16.9
35-44	10.7	11.6	13.5	15.0
45-54	11.1	10.2	9.7	10.4
55-64	9.3	9.5	9.3	8.5
65 and over	10.5	11.2	11.7	12.2
Births (Mil.)	3.1	3.5	4.0	4.0
Families (Mil.)	55.7	58.7	63.3	67.3
Households (Mil.)	71.2	79.7	68.5	96.8
Educational Attainment	100.0%	100.0%	100.0%	100.0%
Elementary or less	21.9	18.3	14.4	11.3
Some high school	15.6	16.3	15.4	14.5
High school graduate	36.2	37.9	38.9	39.3
Some college	12.4	12.5	13.7	14.8
College graduate	13.9	15.0	17.5	20.1

Implications for Plans

Among the implications which the above mentioned changes in demographic patterns will have upon Plans are:

a. The increase in the size of the labor force in the 1980s should have a positive impact on Plans' enrollment and revenues. However, the rate of increase in enrollment is likely to slow as the annual rate of increment in the labor force declines from 2.9 percent between 1975-78, to 2.2 percent between 1980-85, and 1.4 percent between 1985-90.

b. The expected increase in multiple wage earner households is likely to result in an increase in the percent of covered employees who select single, rather than family, coverage. Moreover, as the proportion of the labor force with double coverage increases, pressure is likely to build for employers to provide non-duplicative coverage such as cafeteria-style fringe benefits and cash option plans. An increase in double coverage could result in an increased demand for HMOs, which fill the gaps provided by other health benefit plans.

c. Sales in gap filler, or Medigap, policies will increase with the increase in the number of persons reaching age 65.

d. A labor shortage has been predicted for the 1980s. Incentives may be provided for employees who have reached normal retirement age to remain in the labor force. This could result in an increase in the number of

workers age 55 and over who are covered by employer provided health benefit plans. Moreover, as public expenditures for health care increase, there will be increased pressure from the government to shift primary responsibility for reimbursement of claim costs to private insurers.

e. The mass of mid-career workers could exert pressure on management to encourage the extension of early retirement programs. Employers could encourage early retirement by continuing to provide health benefits for retirees on the same basis as if the individuals were currently employed.

f. The increase in multiple wage earner households, as well as the number of employed workers who are eligible for Medicare, will require an improvement in coordination of benefits.

g. Smaller families are likely to result in lower utilization per family, while double coverage could result in a decline in utilization per policy.

h. Utilization could decline if the increase in female labor participation rates results in reductions in the birth rate, elective surgery, and physician visits because women are unwilling to take time off from work. However, these reductions are likely to be offset somewhat by an aging population who require increased medical attention.

i. The increase in divorces and separations projected for the 1980s is expected to lead to increased utilization of psychological coverage as well as lead to pressure for non-employed ex-spouses to qualify for coverage at a group rate.

j. During the 1970s, there has been a trend to increase paid time off from work, i.e., paid sick-leave, holidays and personal days. If this trend continues, utilization may increase as workers have more time to schedule doctor appointments and elective surgery.

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ECONOMISTS FORECAST RECESSION IN 1980

Since economists use the same government data and similar forecasting techniques, differences between economic forecasts generally are of a relatively small magnitude. However, the forecasts of economic growth and inflation that have appeared since October are an exception. (See the forecasts of real GNP for 1980 in Table 3.) Variations among the estimates reflect different assumptions as to timing and impact of monetary policy, the availability and price of foreign oil in 1980, and the likelihood and effective date of a tax cut.

Table 3

1980 FORECASTS OF REAL GNP

Conference Board	- 0.4%
Data Resources	- 1.5%
Wharton Econometrics	- 0.5%
Chase Econometrics	- 1.7%

Each month, Robert Eggert of Eggert Economic Enterprises compiles a summary of economic forecasts of the leading economists and economic forecasting organizations. According to his November report, the consensus of the 42 economists he contacted was that there will be a recession in 1980 which will be short and shallow, and last 6 to 9 months. There will be only a small decline in business activity in the first quarter of 1980, and even less of a decline in the second quarter, followed by an accelerating rate of improvement throughout the second half. The consensus among the economists was that real GNP will decline by approximately 1 percent in 1980. Inflation will remain in the double digit range and the CPI will be 10-11 percent higher in 1980 than in 1979 as a result of an acceleration of wage gains and the pass-through of higher energy costs. Economists are predicting that the rate of unemployment will increase to 7.5-8.5 percent by the fourth quarter of 1980. Short-term interest rates are forecasted to fall by 4-5 percentage points in 1980.

Impact on Plans

Most economists predict the recession will start this quarter. In the past year, increases in employment in the service sector have more than offset declines in employment in the manufacturing sector. However, forecasters are predicting that this will not continue.

To date, lay-offs have been largely concentrated in the automobile, steel, and rubber industries. Plans will not feel the impact of these lay-offs on revenues until the second half of 1980, at the earliest, since union contracts with employers provide that terminated workers will continue to be covered for 1-2 years, depending upon seniority. However, utilization may increase as workers who are temporarily or permanently laid-off increase their visits to physicians or schedule elective surgery in their free time and/or before health benefits expire.

The Big 3 automakers now have about 100,000 production workers on indefinite lay-off, up from approximately 60,000 in mid-August, and another 40,000 on temporary lay-offs. Some auto analysts predict that Michigan's unemployment rate will reach 8 percent by year end, up from 7.2 percent in October, and average 10 percent in 1980.

The steel industry has laid-off 20,000 workers since June, when hourly employment peaked. Armco's Chairman, C. William Verity, Jr. predicts hard times over the next six months. In November, U.S. Steel reported that it will lay off about 8 percent of its work force, or 13,000 workers. David Roderick, Chairman, indicated that additional lay-offs may be necessary if the government does not take action to aid the steel industry, e.g. by providing guaranteed loans to modernize plant and equipment, by setting higher "trigger" prices, and assessing anti-dumping duties.

The rubber industry has also laid-off workers. Approximately 10 percent of Goodyear's domestic production workers, 15 percent of Firestone's workers, and 9 percent of Uniroyal's workers have been furloughed. Additional lay-offs are expected in 1980.

Other industries vulnerable to increased unemployment include the construction industry as well as manufacturers of furniture and household appliances. For example, the National Association of Home Builders predicts that total construction unemployment will rise from 10 percent to 22 percent or more in 1980. Many forecasters call this an overestimate. However, they do see substantially higher unemployment rates in the construction industry. High interest rates are causing many companies, particularly small businesses, to retrench and to keep employment to a minimum. Meanwhile, employment in energy, aerospace, defense, and export oriented industries is expected to remain strong.

In 1980, workers and unions will continue to seek increases in cash wages and expanded benefits. Most of the latter is expected to come in the form of pensions, pre-retirement counseling and dental and legal services. Wage negotiations will be conducted in the petroleum, construction, steel, aluminium, copper, aerospace, and telephone industries in 1980.

High interest rates will have a positive impact on Plan revenues. This will moderate the need for premium increases. However, high interest rates could result in an increase in slow payments as companies find delay in payment of premiums to be advantageous. High interest rates will also continue to put pressure on Plans to provide alternative financial arrangements.

Labor accounts for the major share of medical care costs. These costs are forecasted to increase in 1980 because of a higher pay standard and pressure on employees to make up for losses in real income in 1979. Furthermore, medical care prices are expected to feel the full impact of inflation in 1980 as the OPEC price increases in 1979 ripple through the economy and affect the price of petroleum based products used by hospitals. Thus, the increase in medical care costs is expected to continue to accelerate in 1980.

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STATUS OF SECOND YEAR PRICE AND PAY STANDARD

Price

The second year price standard for health insurers is expected to be issued by mid-December, according to a spokesman for the Council on Wage and Price Stability (COWPS).

COWPS has already issued the price standard for other industries and groups, including physicians. (Hospitals are under the jurisdiction of HEW.) According to those standards, physician professional earnings are subject to (a) the professional fee standard, (b) the pay standard, or (c) the professional fee standard and the pay standard.

The professional fee standard limits increases in average fees in the two year period October 2, 1978 to September 30, 1980 to 13.5 percent, and increase in single fees to 19 percent.

The pay standard limits increases in wages to 8 percent. (See ECONOMIC REPORT dated October 15, 1979.) Increases greater than 8 percent require COWPS approval.

- Physicians paid by an individual or HMO on fee for services basis are subject to the professional fee standard, and are responsible for complying with that standard.

- Physicians paid on the basis of percentage-of-department-revenues are subject to the professional fee standard. If the hospital bills for the physician, both the physician and the hospital are responsible for complying with the standard.

- Physicians paid on a salary basis by a hospital or HMO are part of an employee group and are subject to the provisions of the pay standard.

- Physicians who are part of a group contracting with a HMO are subject to the provisions of the pay standard. If the pay arrangement between the physician and the group include components for physician compensation and other factors such as office expenses, the physician compensation component should meet the pay standard. In addition, the formula used by the medical group to determine the other components should not be adjusted to circumvent the pay standard.

- Physicians whose professional earnings consist of some combination of salary, fee for services, and percentage-of-department-revenue should comply with all of the appropriate standards.

Pay

In October, COWPS issued an interim pay standard. The final standard was to await the recommendation of the Pay Advisory Committee (PAC). PAC has been meeting weekly since its formation in mid-October. An announcement regarding the general pay standard is expected at its December 18th meeting.

PAC developed out of the National Accord between President Carter and the AFL-CIO leadership. In the spirit of that Accord, Labor agreed to support the President's anti-inflation program of wage and price standards and to participate in a committee which would recommend a pay standard. Thus, COWPS, which originally had responsibility for developing both the pay and price standards, was relieved of the responsibility for formulating a pay standard. (A Price Advisory Committee has been formed to review the second year price standard developed by COWPS. The Price Advisory Committee's first meeting is scheduled for mid-December.)

PAC consists of 18 members, with 6 representatives each from Labor, Management, and the Public. Among the Labor representatives are Lane Kirkland, Frank Fitzsimmons, Douglas Fraser, and Glenn Watts. The chairman of the Committee is John Dunlop, Harvard economics professor, former Secretary of Labor, and veteran of all wage stabilization programs since World War II.

Dr. Dunlop firmly believes that a successful wage stabilization program requires the participation of Labor and Management in the formulation of policy, as well as the drafting of the final standard. Furthermore, he believes that subcommittees, in which there is equal participation of Labor and Management, and consisting of members with a special interest and expertise, should make policy recommendations to the entire committee. He also believes that agreement on smaller issues will hasten agreement on the general pay standard.

Subcommittees have been formed to deal with tandem relationships, incremental pay, and the low wage exception. The following progress has been made on each of these issues:

- PAC has transmitted a recommendation that broadens the definition of tandem relationships to permit workers without COLAs, but whose wages bear a historical relationship to workers with COLAs, to receive larger wage increases so as to catch up. For example, a Plan in which union workers have COLA contracts, but does not provide COLAs to management staff, may increase the latter's wages so as to maintain parity.

- The incremental pay subcommittee has agreed in principle to recommend exemption for incremental pay which is job related, e.g. increases which reflect skill level or educational attainment. The subcommittee is continuing to discuss incremental pay based upon longevity.

- PAC has approved a low wage exception which exempts workers with average hourly earnings of $4.00 per hour or less, and establishments in which the average wage of all workers is below a given hourly rate to be determined.

Although a recommendation for the general pay standard is expected shortly, the Committee has not given an indication of its nature. Dr. Dunlop is a strong chairman. He is known to be concerned about the impact of a wage stabilization program on collective bargaining, and is anxious to improve bargaining as well as industrial relations. He believes that a successful wage stabilization program should not violate established wage patterns and relationships. For example, if it has been the pattern to reward younger employees with larger pay increases than senior management, he believes that such a relationship should be allowed to continue. If it has been the practice for a particular industry to grant its workers larger increases than another industry with lower productivity gains, be believes that practice should be allowed to continue. Thus, Dunlop does not favor a single standard, similar to the one in effect, which treats all employee groups and all industries alike.

Dr. Dunlop, a noted labor economist, also does not believe that the primary cause of inflation is increased wages. Rather, he believes that inflation is a complex issue with many interrelated factors. Thus, he is not expected to favor a wage stabilization program which calls for substantial reductions in real wages. In contrast, COWPS believes that the inflation is directly related to the rapidly increasing wage-price spiral, and that wage and price controls are needed to contain inflationary pressures. Thus COWPS's interim pay standard calls upon workers to take a cut in real wages.

Finally, Dr. Dunlop is concerned about due process in a wage stabilization program. Thus, a committee consisting of staff members of Labor and Management has been directed to examine the current procedures for determining noncompliance. It is expected that PAC will make a recommendation to COWPS concerning the appropriate forum for a public hearing, on noncompliance and the use of sanctions in a voluntary program.

IMPACT OF RECESSION ON NEW ENGLAND

In the past, New England has been affected by economic downturns more than other regions. This has resulted from the fact that a high share of the area's labor force is employed in durable goods manufacturing (the industrial sector most vulnerable to economic cycles), the area's industry is energy intensive (and therefore suffers from high energy costs) and posseses an aging capital stock.

However, several of the region's leading economists are predicting that the New England region will not bear the brunt of the expected recession in 1980. For example, economists at the First National Bank of Boston predict that the region's output will decline by 1½ to 2 percent, or half a percentage point less than they predict for the nation as a whole, and that employment will increase by 0.8 percent, or about twice the national average. The reasons for their optimism include the following:

1. The region's recent economic performance relative to the nation has been positive. This is evidenced by the 11.6 percent increase in manufacturing employment compared to a 9.2 percent increase for the nation as a whole over the last three years.

2. The area contains a large proportion of the nation's defense contractors and companies in high technology fields, which are industries expected to remain strong in 1980.

3. New industries can be expected to be attracted to New England as a result of the area's highly educated and skilled labor force, and its relatively low wage rate (91 percent of the national average).

4. The region's comparative economic disadvantage, its taxes, is being reduced. For example, Massachusetts, which accounts for half of the region's output and a state of notoriously high taxes, reduced state and local taxes this year. Similarly, in Connecticut, which accounts for one third of the region's output, taxes are now 2 percent below the national average, compared to 6 percent above the national average six years ago. Moreover, the absence of a personal income tax in Connecticut continues to attract businesses from New York City to Fairfield County. Taxes in New Hampshire are 19 percent below the national average, and can be expected to continue to attract new business.

Areas of concern still remain. For example, forecasts for Rhode Island show a bigger decline in manufacturing employment than in other states. In addition, the sharp rise in gasoline and heating oil prices predicted for 1980 are expected to reduce a New Englander's purchases of other goods and services, and thereby affect retailers, restaurants, hotels, etc. However, the region's economists currently believe that even if a New Englander is short of cash, he probably will not be unemployed in 1980.

IMPACT OF RECESSION ON NEW YORK CITY

The ECONOMIC REPORT dated October 15, 1979 contained an article on Citibank's economic predictions for New York City in 1980. Citibank has subsequently revised its estimates to reflect the recent tightening of credit by the Federal Reserve. Both Citibank and Chase Manhattan Bank, which publishes a corresponding prediction for both New York City and New York State, now feel that the recession will be "moderate", rather than "mild". Citibank believes the recession has already begun, although the figures don't show it, while Chase expects the recession to begin in the next few months. Both banks expect the City's job loss to be between 30,000 and 60,000 in 1980, and that the manufacturing sector will be hardest hit. Employment in the service sector is expected to continue growing in 1980, although at a slower pace. They do not expect a sharp drop in construction jobs because construction activity is locked into long-term contracts.

Citibank continues to believe that the City is in better shape than it was prior to the last two recessions, and thus should be able to weather an economic downturn better than it did in the past. It cites as evidence of the City's economic health increases in construction activity, retail sales, hotel occupancy rates, and a decline in public assistance. In addition, it claims that the City's competitive position has improved as taxes have been reduced, and wage rates in key industries, as well as consumer prices, including medical care, have increased more slowly than in the rest of the nation.

However, an article in the November issue of Fortune disputes Citibank's conclusions. It describes the City's economic environment as inimical to the financial interests of manufacturers and small businesses. Robert Lekachman of Lehman City University of New York (CUNY), and William Lawrence of Wharton Econometrics, also believe that the recession will have a more adverse impact on the City than the banks are presently predicting.

Chase is predicting that in 1980 the unemployment rate for New York State will be slightly less than the 10 percent rate it is predicting for the City, but still more than the 7 percent it is forecasting for the nation as whole.

The banks are predicting that in 1981, the City's economy will probably resume the slow, steady growth that occurred between 1977 and 1979, and that that trend will continue throughout most of the 1980s. These conclusions have been echoed by the Federal Department of Labor and a survey of opinions of local businessmen published in November by Chemical Bank.

INFLATION REPORT

Consumer Price Index

The Consumer Price Index for All Urban Consumers (CPI-U) increased 0.9 percent before seasonal adjustment in October to 225.4 (1967=100). The Consumer Price Index for Wage Earners and Clerical Workers (CPI-W) increased 0.8 percent before seasonal adjustment to 225.6 (1967=100). The CPI-U and the CPI-W was 12.2 and 12.4 percent higher than in October 1978 respectively.

About two thirds of the October increase (on a seasonally adjusted basis) was attributable to higher home ownership costs. The rate of increase of energy prices slowed significantly in October, while the rate of increase of food prices accelerated, after easing in the third quarter.

Government economists report that it is unlikely that increases in the CPI will slow in the next few months. The October CPI does not take into account the higher credit costs which followed the credit tightening moves of the Federal Reserve in October. Although the prime rate is below its November peak of 15 3/4 percent, it is still higher than in October. Robert Russell, Director of COWPS, told the Congressional Joint Economic Committee that the increase in mortgage interest rates will begin to appear in the November CPI, and then show up "with a vengeance in the December report."

Criticism of the CPI

The use of the CPI to measure inflation has been under attack by some economists in recent months. They call the CPI a "flawed measure of inflation", primarily because it overemphasizes, or gives too much weight to, the cost of newly purchased homes.

The housing component of the CPI reflects the price of shelter which includes rent and home ownership, and fuel and other utilities. Home ownership includes home purchase prices, financing, taxes, and insurance. However, actual consumer outlays on home ownership rise more slowly than do current costs of home ownership because only a small number of homes change hands in any given year. Most home owners continue to pay costs established in previous periods. When home purchase prices, financing, taxes, and insurance are excluded from the CPI, the adjusted index increased at an 11 percent annual rate between the second and third quarters, rather than 13 percent.

These economists also criticize the CPI because "it contains an outdated version of the consumer's market basket" and thus is a distorted measure of inflation.

The CPI, a fixed weight index, measures changes in the dollar cost of items that the "average" urban consumer bought in 1972-73. The market basket of goods and services purchased by consumers has undergone substantial changes, since 1972-73. The new consumption patterns are, to a large extent, the result of changes in relative prices. Consumers tend to buy fewer items whose prices have risen relative to all other prices, and buy more items whose relative prices have fallen. For example, the increase in the relative price of meat,

particularly beef, since 1972, has caused consumers to shift purchases from beef, and meat in general to poultry, eggs, and non-meat, high protein substitutes. These shifts have mitigated the increase in the cost of beef, but are not reflected in a fixed weight index. In addition, the sharp increase in the relative price of energy since 1973 has led consumers to conserve energy and so reduce the portion of constant, 1972 dollar real income they allot to it. At the same time, consumers have increased their purchases of items such as clothing, where the relative price has fallen since 1972. Thus, these economists criticize the CPI for overstating the overall inflation rate by overstating the weight of items such as food and energy and understating items such as clothing.

Medical Care Prices, CPI-U, Unadjusted

a. September 1979 to October 1979

- Medical care prices increased at the same rate as the all items index, while medical care services increased at a slower rate than the price of services less medical care. In addition, in each month since February of this year, the increase in medical care prices has been below or equal to the increase in the all items index.

- Medical care prices increased at the same rate as in October 1978, while the all items and services less medical care indexes increased at more rapid rates.

- Prices of physician services increased at a substantially slower rate than prices of all items, services less medical care, and physician services in October 1978.

- Hospital and other medical care services increased more rapidly than the all items index and services less medical care. However, approximately 21 percent of community hospitals are on a fiscal year beginning in October, and generally make rate adjustments in that month. The impact of these rate adjustments is reflected in the CPI for October and November. Increases in hospital and other medical care services was greater than in October one year earlier.

	PERCENTAGE CHANGE	
	September 1978 to October 1978	September 1979 to October 1979
All items	0.8	0.9
Medical Care	0.9	0.9
Services less medical care	0.9	1.2
Medical care services	1.0	1.0
Physician services	0.6	0.5
Hospital and other medical care services	1.2	1.4

Source: Bureau of Labor Statistics

b. October 1978 to October 1979

- The price of medical care and medical services fell relative to the price of all items and services less medical care. Moreover, the rate of increase in medical care prices has remained below the all items index throughout 1979.

- October was the fourth consecutive month in which hospital room prices increased at a rate at or below the all items index, and is the smallest 12 month increase since 1978.

	PERCENTAGE CHANGE	
	October 1977 to October 1978	October 1978 to October 1979
All items	8.9	12.2
Medical care	9.7	9.4
Services less medical care	8.0	12.2
Medical care services		9.9
Physician services	8.3	9.5
Hospital Room	11.6	10.6

Source: Bureau of Labor Statistics

c. Long Term Trends

- The all items index and components such as food, transportation and housing are increasing above their levels of recent years, while medical care is increasing at rates at or below long term trends.

Average Compounded Percent Changes in Selected CPI Components October-to-October Periods

	1974-79	1978-79
All items	8.1	12.2
Food	7.5	9.7
Transportation	9.3	17.4
Housing	8.7	13.5
Energy	13.4	35.8
All items less medical care	8.0	12.4
Medical care	9.5	9.4
Physicians' services	9.7	9.5
Hospital room	12.4	10.6

Source: AHA, INFLATION REPORT, Volume 2, Number 12, p.4.

Other Indicators of Changes in Hospital Costs

Each month the AHA publishes the Hospital Cost Index (HCI), which reflects changes in the price of a hospital market basket consisting of 46 procedures. It also publishes a hospital intensity index (HII), which reflects changes in the quantity of these same procedures. The real service volume index (RSV) adjusts the intensity index (HII) for changes in seasonally adjusted patient days. The data used in the construction of these indexes is obtained from approximately 700 hospitals. In the period ending August 1978 to August 1979, the HCI, the HII, and the RSV increased 9.6 percent, 0.3 percent, and 2.2 percent, respectively. Preliminary figures ending September 1978 to September 1979, indicate that the HCI, the HII, and the RSV increased 9.5 percent, 0.7 percent, and 2.6 percent, respectively.

	PERCENTAGE CHANGE	
	August 1977 to August 1978	August 1978 to August 1979
Hospital cost index	6.7	9.6
Hospital intensity index	4.8	0.3
Real service volume	6.7	2.2

Source: AHA

The AHA also publishes information on changes in hospital expenses and utilization from the National Panel Survey, a monthly survey of 1,760 community hospitals representing a cross section of the industry. Results for September, the latest month for which information is available, appears in the table below. In September surgeries declined for the first month since April 1978.

	Month of September 1977 to September 1978	Month of September 1978 to September 1979	Year-to-Date 9 Months 1977 to 9 Months 1978	Year-to-Date 9 Months 1978 to 9 Months 1979
Total expenses	12.5	12.7	12.8	13.1
Admissions	- 0.4	3.2	0.5	2.6
Inpatient days	- 0.2	1.8	0.2	1.4
Outpatient visits	- 1.7	0.8	1.4	- 0.9
Adjusted Admissions	- 0.1	3.3	0.9	2.8
Length of Stay	0.4	- 1.4	- 0.3	- 1.2

Figure I

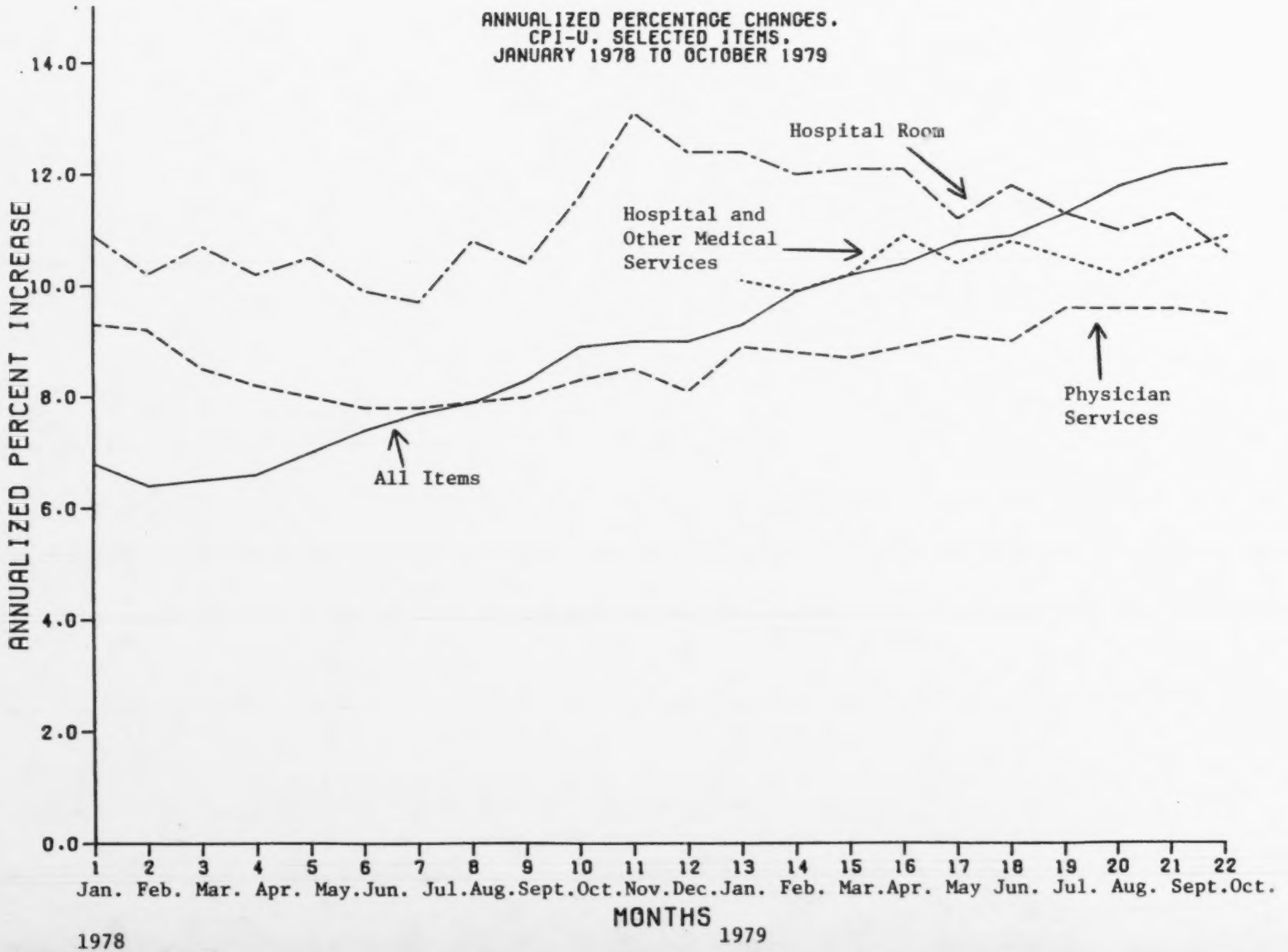
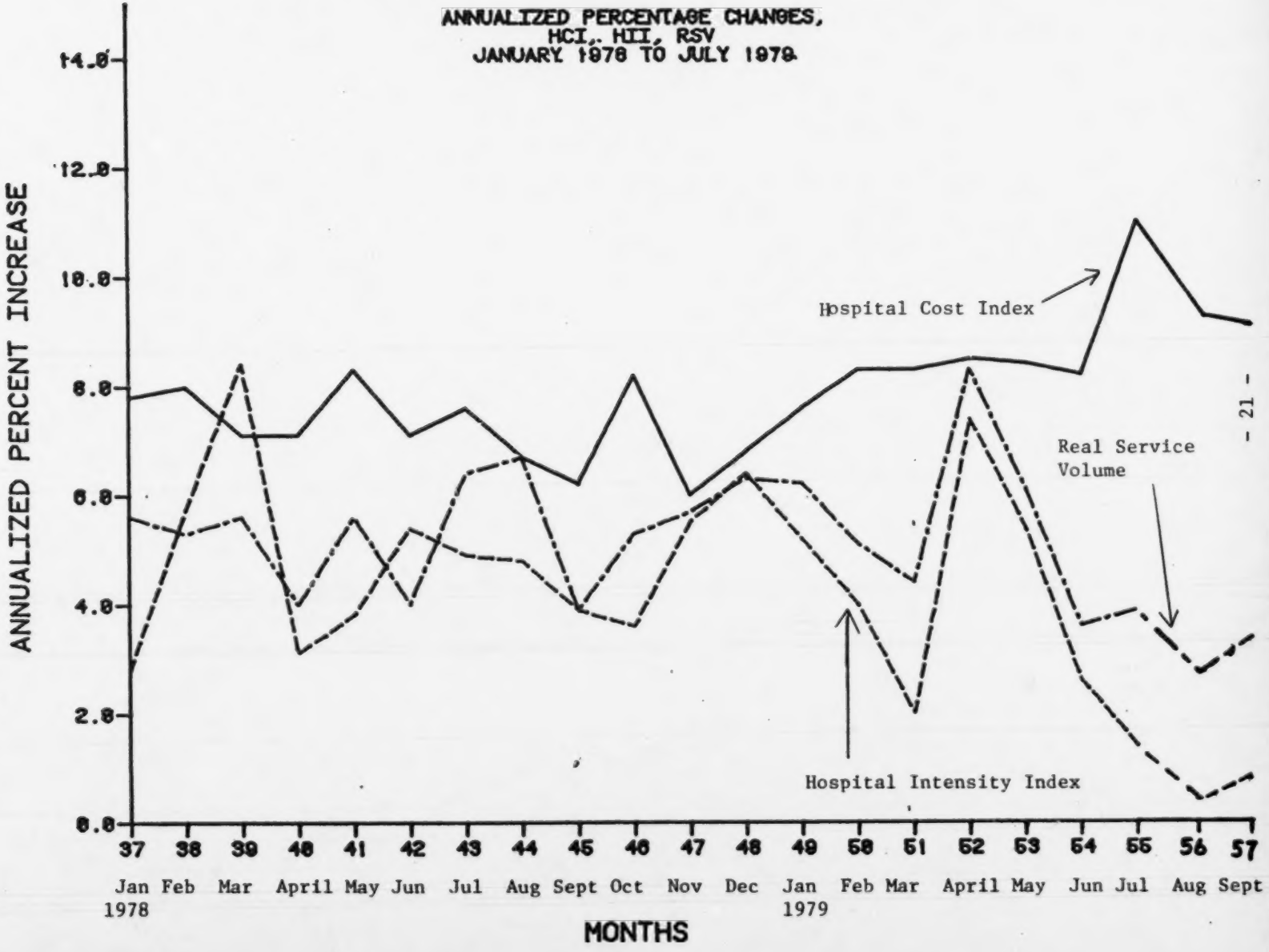

ANNUALIZED PERCENTAGE CHANGES.
CPI-U. SELECTED ITEMS.
JANUARY 1978 TO OCTOBER 1979
ANNUALIZED PERCENT INCREASE
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Hospital Room
Hospital and
Other Medical
Services
Physician
Services
All Items
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22
Jan. Feb. Mar. Apr. May. Jun. Jul. Aug. Sept. Oct. Nov. Dec. Jan. Feb. Mar. Apr. May Jun. Jul. Aug. Sept. Oct.
MONTHS
1978
1979

Figure II


ANNUALIZED PERCENTAGE CHANGES,
HCI, HII, RSV
JANUARY 1978 TO JULY 1979
ANNUALIZED PERCENT INCREASE
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Hospital Cost Index
Real Service Volume
Hospital Intensity Index
37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57
Jan Feb Mar April May Jun Jul Aug Sept Oct Nov Dec Jan Feb Mar April May Jun Jul Aug Sept
1978
1979
MONTHS

Percent Changes in CPI-U,
Selected Items, all U.S. Cities
(Unadjusted)

	September	October	September 1978 - September 1979	October 1978 - October 1979
All Items	1.0	0.9	12.1	12.2
Medical Care	0.8	0.9	9.5	9.4
Medical Care Commodities	0.5	0.5	7.4	7.3
Medical Care Services	0.8	1.0	9.9	9.9
Professional Services	0.6	0.6	8.8	8.4
Physician Services	0.7	0.5	9.6	9.5
Dental Services	0.6	0.6	8.3	7.7
Other Professional Services	0.4	0.3	7.0	5.9
Other Medical Care Services	1.0	1.4	10.9	11.3
Hospital and Other Medical Care Services	0.8	1.4	10.6	10.9
Hospital Room	0.6	1.0	11.3	10.6
Other Hospital and Medical Care Services	1.2	1.7	10.1	11.1
Services	1.3	1.2	11.6	11.9
Services, Less Medical Care	1.3	1.2	11.8	12.2

Percent Changes in CPI-W
Selected Items, all U.S. Cities
(Unadjusted)

All Items	1.0	0.8	12.4	12.4
Medical Care	0.9	1.0	9.8	9.9
Medical Care Commodities	0.3	0.4	7.7	7.4
Medical Care Services	1.0	1.1	10.3	10.4
Professional Services	0.9	0.8	9.7	9.6
Physician Services	1.1	1.2	10.7	11.4
Dental Services	0.8	0.2	9.1	8.2
Other Professional Services	0.2	0.4	6.6	6.0
Other Medical Care Services	1.1	1.5	9.4	11.3
Hospital and Other Medical Care Services	0.9	1.3	10.2	10.2
Hospital Room	0.6	1.4	10.8	10.4
Other Hospital and Medical Care Services	0.9	1.3	10.5	10.1
Services	1.3	1.2	13.4	12.3
Services, Less Medical Care	1.3	1.3	12.1	12.5

Source: Bureau of Labor Statistics

The Economic Report is a publication of the Health Economics Research Department of the Blue Cross and Blue Shield Associations; Edward S. Mills, Vice President.

For information on Changing Demographic Patterns and Their Probable Impact on Plans, Economists Forecast Recession in 1980, Status of Second Year Price and Pay Standard, Impact of Recession on New England, Impact of Recession on New York City, and Inflation Report contact Dr. Rachel Golden, Research Economist, (312) 440-5539. Other requests, contact Linda M. Krasovskis, Editorial Assistant, (312) 440-5671.

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January 31, 1980

TO: Chief Plan Executives

FROM: Edward S. Mills, Vice President, Health Economics Research

SUBJECT: Economic Report

IN THIS ISSUE

- Economic Forecasts of Inflation, Medical Care Costs and Hospital Utilization
- 1980 Price and Wage Standards for Plans
- Economic Forecasts for the Chicagoland Area
- Inflation Report

  CPI-U (percentage changes in annual average, end of year, one month change, regional variations)

  AHA Panel Survey

  AHA Hospital cost and intensity indexes

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ECONOMIC FORECASTS OF INFLATION, MEDICAL CARE COSTS AND HOSPITAL UTILIZATION

I. Economists Uncertain About the Direction of the Economy

In the 1950s and 1960s, economists' forecasts were generally accurate within a small range of error. However, this is no longer the case. Economists admit that they are unable to predict the economic environment with any degree of certainty. This is because our nation's economic health is more dependent than ever on political events in the Middle East, an area which supplies about 40 percent of our oil, and which is extremely unstable and volatile. Last year's revolution in Iran was responsible for the increase in OPEC prices, which added about 2 percentage points to our inflation rate. It is uncertain what changes will take place in the price of petroleum during 1980. The Russian invasion of Afghanistan has resulted in a shift in U.S. foreign policy away from detente. The anticipated increase in defense spending is expected to add to inflation in 1981. Further, there is increasing concern that the stability of the international financial system could be undermined by developments in the Middle East.

An additional source of uncertainty is consumer behavior. Throughout 1979, economists warned that a recession was coming because consumers would reduce spending in response to rapidly rising prices. Instead, consumers added to their debt and reduced their savings. They did not stop spending, and the recession did not materialize. Economists are warning that if the savings rate increases to 6-7 percent of personal income, the average rate for the past decade, from 3.3 percent, which is the current rate, a severe recession may be in the offing. However, if current savings rates continue to prevail, the recession will be mild.

In spite of these uncertainties, economists continue to make projections, and corporate planners, marketing personnel, and actuaries continue to use these projections as a basis for making major business decisions. The economic forecasts of inflation presented below represent a consensus of major forecasting organizations, as well as some dissents from the standard forecast.

II. Inflation

a. Consensus forecast: 11 percent inflation, recession, and no increase in OPEC price in 1980

Inflation (the increase in the Consumer Price Index) is currently 13.3 percent. The consensus forecast is that it will be approximately 11 percent in 1980, and approximately 8.5 percent in each of 1981 and 1982. In general, the estimates which form the basis of the 1980 consensus forecast assume no increase in OPEC prices, a tax cut, a 5 percent increase in real defense spending, and no sudden change in savings rates.

A majority of economists are predicting a mild recession in 1980 (about a 1 percent decline in real GNP), ending in late 1980 or early 1981. They expect the recovery from the recession to be slow, and high unemployment to persist through 1981.

High inflation is forecast for 1980, even through the factors responsible for the 1979 inflation (rapidly rising interest rates, food, housing and energy prices) are not expected to recur. High inflation is expected to continue because of rapidly rising labor costs, and past OPEC price rises rippling through the economy. Labor costs account for approximately 67 percent of production costs. In 1979, unit labor costs increased by approximately 10 percent. They are not expected to decelerate in 1980. Thus, the base under inflation is at a relatively high level.

b. Dissent: No recession in 1980, no short term relief from inflation or high interest rates

A number of economists (1-3 out of 10) are convinced that there will not be a recession in 1980. Instead, they believe that the economy will continue on a path of slow, or sluggish, growth as a result of an increase in real defense spending, an increase in business investment, and a Korean War type of inflation psychology in which consumers accelerate spending in anticipation of higher prices and shortages. The postponement of a recession will also postpone relief from inflation and high interest rates. (Some economist are predicting that short term and long term interest rates are about to move higher. For example, one month from now they expect treasury bill rates of $13\frac{1}{2}$ percent and a prime of at least 16 percent).

In general, economists do not believe that the postponement of the recession is good for the economy. President Carter is not expected to recommend a tax cut unless a recession occurs. Many economists and business leaders believe that a tax cut is needed to bring about the investment in plant and equipment and human resources that will insure long term economic growth and price stability.

c. Dissent: Higher OPEC prices, higher inflation, higher interest rates

Most economics believe that OPEC prices will not increase in 1980. (However, several OPEC members raised their crude prices by 8 percent, retroactive to January 1, 1980.) These economists expect demand to decline in 1980, because of a recession in the U.S. and Europe, and increased supply resulting from continued high production by Saudi Arabia. However, a few economists are predicting that OPEC prices will increase in 1980 as a result of an escalation of armed conflict in the Middle East, periodic cutbacks or supply interruptions by OEPC countries, and/or growing expectation of eventual

confrontation between the U.S. and the USSR. They predict that higher oil prices will cause inflation to increase to 14 percent in 1980, and interest rates to rise. (The increase in OPEC prices would cause the value of the U.S. dollar to fall. In order to offset this, the Federal Reserve would be forced to raise interest rates even further, or at least not ease them to the degree usually associated with recession.)

d. Economists concerned about controls on interest rates, wages and prices

Many economists are concerned that if inflation increases and/or there is a run on the U.S. dollar, the Government will institute credit controls, as well as wage and price controls. In fact, about 80 percent of the economists responding to Bob Eggert's Blue Chip Economic Indicators poll in January recognized a wage-price freeze this year as at least a possibility.

III. Medical care prices

The high rate of inflation is expected to prevent the increase in medical care prices from decelerating before 1982. See Table 1.

TABLE 1
ESTIMATES OF RATES OF INCREASE IN MEDICAL CARE PRICES, 1979-1982

	1979	1980	1981	1982
Medical care	9.3%*	9.0-9.5%	9.0-9.5%	8.5-9.0%
Physician services	9.1%*	9.0-9.5%	9.0-9.5%	8.5-9.0%
Dental services	7.8%*	7.5-8.0%	7.5-8.0%	7.0-7.5%
Hospital room charges	11.4%*	10.5-11.0%	9.5-10.0%	10.0-10.5%
Hospital "market basket"**	10.3%**	10.8%**	NA	NA
Medical commodities	7.2%*	7.5-8.0%	7.5-8.0%	7.5-8.0%

*Bureau of Labor Statistics, CPI-U, U.S. city average.
**American Hospital Association, Office of Policy Studies, POLICY BRIEF, Number 20, Fourth Report to the National Steering Committee of the VE, December 17, 1979, p. 7

The health care sector is labor intensive. Past inflation is forcing a continued rapid rise in wage gains. At present, inflation and wages are increasing faster than medical care prices. Economists do not anticipate a deceleration in medical care prices until inflation and wage gains moderate appreciably.

In recent months, the CPI index of dental services has increased at an above average rate. (See article on Inflation Report in this issue.) The increase is largely attributed to the recent rise in gold and silver prices. A continuation of international economic instability could put further pressure on prices of dental services.

Some economists believe that inflation in the hospital industry is caused by costs outside the hospital sector pushing up hospital costs, i.e., a cost-push inflation. For example, they attribute increases in hospital labor costs to tight labor markets, minimum wage laws, the growth of unionization, and a "catch up" process to bring hospital wage schedules in line with the rest of the economy. With the exception of 1974 and 1979, general productivity has increased. Increases in productivity cause wage rates to rise faster than prices. Hospitals must meet these higher wage rates to attract and keep an adequate labor force. However, hospitals have limited ability to increase their productivity, mainly because of their inability to substitute less costly capital for more

expensive labor. Thus, the hospital "market basket" tends to increase faster than the CPI. However, during periods of rapid inflation, prices tend to increase faster than wages. According to the AHA, hospital labor costs (wages and benefits) are likely to increase 9.6 percent, in 1980. In addition, the prices of the goods and services hospitals purchase in 1980 are likely to increase by 12.4 percent, more rapidly than the CPI. Thus the AHA expects the cost of the hospital "market basket" to increase 10.8 percent in 1980.

However, it should be recognized that even though inflation is expected to moderate slightly in 1980 (from 13-14 percent to 11 percent), and medical care prices are expected to continue to increase at current rates, the latter are projected to increase at a slower rate than the former, i.e., 9.0-9.5 percent vs. 11 percent. The decline in the relative price of medical care could result in an increase in consumption of health care services.

IV. Hospital Utilization

According to the AHA, adjusted admissions will most likely increase by 3.3 percent in 1980, in contrast to 2.6 percent in 1979. Inpatient admissions are most likely to increase by 1.9 percent, and outpatient admissions by 1.2 percent in 1980. In 1979, inpatient admissions are estimated to have increased by 2.1 percent and outpatient admissions to have declined by 0.5 percent. (See Table 2.)

TABLE 2
ESTIMATES OF PERCENTAGE INCREASES IN HOSPITAL UTILIZATION

	1979	1980*
Adjusted admissions	2.6	3.3
Inpatient admissions	2.1	1.9
Outpatient admissions	-0.5	1.2

* AHAs estimate of "most likely" in 1980.
Source: American Hospital Association, Office of Policy Studies, POLICY BRIEF, Number 20, Fourth Report to the National Steering Committee of the Voluntary Effort, December 17, 1979, pp. 5, 6, 7.

Typically, a recession induces an acceleration of hospital utilization as persons who have been laid off, or whose workweek has been reduced, seek to take advantage of their health benefits before they expire, or in their additional leisure. However, as the recovery begins, there is generally a deceleration in the rate of increase in hospital utilization. The AHA expects this pattern to be repeated in 1980, and that the rate of increase in hospital utilization will decelerate in 1981.

V. Impact of Inflation on Plans in 1980

a. Over the next 12 months, Plans can anticipate an economic environment which includes a recession, or sluggish growth, continuing double digit inflation, and steadily rising unemployment. (Unemployment is expected to reach 7.5-8 percent by the end of 1980.)

b. Claim costs will probably accelerate because of an acceleration in utilization and no deceleration in medical care costs.

c. Administrative costs will probably accelerate in response to the new wage standard for the second program year. (See article on wage standard in this

issue.) The Pay Advisory Committee has recommended a wage standard for companies without COLAS of 8.5 to 10.5 percent, in contrast to the 7 percent standard for the first program year.

d. The standard forecast is for a decline in interest rates in 1980. However, if inflation increases, interest rates will also increase, and net investment income will expand. If this occurs, Plans will be able to absorb some of the increase in claim costs, and thus restrain premium increases. However, if interest rates fall, and net investment income is reduced, Plans may be unable to contain premium increases without dipping into reserves.

e. Inflation and the 1980 price standard will make it difficult for Plans to increase or maintain reserves.

f. Consumers' real income is expected to continue to decline in 1980. Thus, workers and unions alike will continue to pressure management for additional health care benefits, particularly those which cover ordinary medical care expenditures such as dental care, vision care, and drugs, as well as increased limits for existing health benefits.

g. Rapid inflation and high unemployment may cause many workers and unions to wade off health benefits for additional cash and pensions.

h. Corporate profits are weakening and operating profits are expected to decline further in 1980. Thus, business can be expected to be increasingly concerned with the cost effectiveness of existing health benefit plans, and to be reluctant to acquire new benefits that do not hold the promise of providing service efficiently and at minimum cost.

i. High interest rates can be expected to put further pressure on Plans to provide favorable retention rates and to make alternative financial arrangements for customers.

j. Dental fees can be expected to continue to accelerate if the price of gold and silver continues to climb. Moreover, dentists may begin to itemize their bills, and to separate lab fees, input prices, and fees for professional services.

1980 PRICE AND WAGE STANDARDS FOR PLANS

I. Introduction

The voluntary wage and price standards are part of the Administration's anti-inflation program. The standards are issued and monitored by the Council on Wage and Price Stability (COWPS). The 1980 price standard for health insurers is an exception to the general price standard and was issued by COWPS on January 8, 1980. A final wage standard is expected to be issued shortly. It is expected to reflect the recommendation of the Pay Advisory Committee (PAC) which was forwarded to COWPS on January 22, 1980.

The price standard for health insurers limits the increase in inflation trend factors (cost and utilization) that Plans use to set premiums. The wage standard limits increases in cash and fringe benefits that Plans and other employers can grant their employees. Thus the wage standard will affect sales of health insurance.

The 1980 price standard for health insurers and the PAC recommendation for a wage standard reflect some of the inflation that has occurred since the Administration's anti-inflation program was introduced. For example, the 1980 standard permits Plans to pass on a larger portion of claim cost increases than the 1979 standard (the 1980 standard calls upon Plans and Commercials to decelerate their base period inflation trend factors by approximately 10 percent; the 1979 standard was designed to achieve a 15 percent deceleration). Although a majority of Plans were in compliance with the 1979 price standard, and the 1980 price standard is not as restrictive as the 1979 standard, Plans will be under great pressure in the coming year to contain costs. The anticipated recession is expected to increase utilization and reduce enrollment. The inflationary

momentum is expected to result in increased health care costs. In addition, the anticipated decline in corporate profits is expected to lead to increased scrutiny of the cost effectiveness of existing health insurance coverage.

The PAC recommended a wage standard for the second program year (which began in October 1979) with a range of 7.5-9.5 percent. It also recommended that the 1 percent equity adjustment for companies without COLAs, which was part of the interim wage standard for the second program year, be added to the first year standard. (For an explanation of the equity adjustment, see Economic Report for October 1979.) This would increase the first year wage standard from 7 percent to 8 percent. Thus, if an employer's compensation package does not contain a COLA and the employer was in compliance with the 7 percent standard for the first program year, it may carry the 1 percent equity adjustment forward and increase wages in the second program year by up to 10.5 percent, rather than up to 9.5 percent. However, COWPS is the government agency which will issue the final wage standard. It is seeking PAC support for a final wage standard that would limit companies without COLAs to the upper half of the 7.5-9.5 percent range, or to 8.5-9.5 percent, and companies with COLAs to the lower half of the 7.5-9.5 percent range, or 7.5-8.5 percent. However, PAC may not agree to change its recommendation.

The PAC, in response to union concerns, is also considering a "separate and operational set of standards regarding pensions". (One of labor's major goals in 1980 is to increase pension benefits for workers and retirees.) If approved, employers would be permitted to exempt most or all of their pension benefit increases from the wage standard, and thus utilize all or substantially all of the increase in compensation permitted under the wage standard to provide increases in cash and/or fringes, including health benefits. Plans would benefit by this change.

II. Background of the Standards

COWPS issues and monitors the price and wage standards which are part of the Administration's anti-inflation program. In addition, it studies individual sectors of the economy which contribute to inflation, and makes recommendations to other government agencies on ways to achieve improved price behavior. For example, HEW used COWPS data to promote the 1977 Hospital Cost Containment Act.

The price standard for health insurers is an exception to the general price standard. The general price standard, including exceptions, affects approximately two-thirds of U.S. businesses. The wage standard affects approximately two-thirds of American workers.

The price and wage standards are based upon the assumption that (1) inflation is attributable to a wage-price spiral, and (2) administered, rather than competitive, prices are the rule rather than the exception, i.e., firms set prices to cover production costs and to maintain the share of national income which accrues to labor and profit, rather than allow prices to be set by supply and demand in the marketplace. Furthermore, once the wage-price spiral begins, it gains momentum and is difficult to restrain without causing a loss in real output and a sharp increase in unemployment.

COWPS economists recognize that the federal government has contributed to inflation through its expansive monetary policy, a bias toward fiscal stimulus which has caused large deficits, a tax system which has discouraged capital formation, and the implementation of programs which satisfy special interests groups (e.g., government price supports for agricultural and industrial commodities, environmental, health and safety standards, and transfer payments to nonincome producing groups) in a way that distributes their costs across all groups. However, the price and wage standards are not directed at modifying government behavior . Instead, they are intended to modify the behavior of managment and workers by setting limits to the amount of inflation that can

be "passed on". The intention of the standards is also to distribute the cost of restraining inflation across all groups, rather than to force a few groups to bear the brunt.

The standards are voluntary; COWPS relies on publicity to obtain compliance. Once COWPS determines that a company's price increases do not comply with the standard, it disseminates this information to the media with the expectation that the offending company will roll back its excessive price increases, rather than be exposed to unfavorable publicity. In addition, companies seeking government contracts of $5 million or more are required to certify compliance with the standard. However, it is not clear to what extent the various government agencies have taken non-compliance into account in awarding contracts, licenses, etc.

There are many economists who disagree with COWPS' analysis of inflation and with the wage and price standards. They believe that artificially restraining prices and wages causes a misallocation of resources, and that once restraints are lifted, wages and prices will increase rapidly to accommodate the excess demand. This occurred in 1975, when the Economic Stabilization Program (ESP) was ended. They also believe that the present program encourages unionization because the big unions have been able to obtain wage increases for their members which have been in excess of the guidelines. These economists would prefer that the Government restrain inflation by reducing the deficit, moderating increases in the money supply, and pursuing policies that increase capital formation and productivity. However, economists admit that the standards held increases in both wages and prices below what they otherwise would have been in 1979. (Interest rates, energy prices, food and housing prices are not subject to the price standard.)

III. 1980 Price Standard for Health Insurers

In general, the 1980 price standard is less restrictive than the 1979 standard. It was designed to pass through some of the increase in claim costs that were experienced in 1979. The 1980 standard continues to restrain premium increases by limiting increases in inflation trend factors (cost and utilization).

The price standard imposes reductions in base period inflation trend factors which exceed 8 percent. Thus, a Plan's revenue weighted average of inflation trend factors, or each of its inflation trend factors, should be no more than:

1. 100 percent of the base period inflation trend factor, if the base period factor is less than 8 percent, or

2. 8 percent plus 80 percent of the amount by which the base period inflation trend factor exceeds 8 percent, if the base period factor is 8 percent or more.

A Plan with a base period inflation trend factor of 10 percent would be in compliance with the price standard if it utilized an inflation trend factor of 9.6 percent. The 1979 standard would have allowed the same Plan to utilize an inflation trend factor that did not exceed 8.9 percent.

The price standard anchors the base period, in contrast to the 1979 standard which contained a floating base period. The base period inflation trend factor is either the average of actual trends in use on April 1, 1978, July 1, 1978 and October 1, 1978 (the same as in the 1979 standard), or the most recent 12 month period for which data was available on January 1, 1980.

If a Plan can separate base period price and utilization changes, and utilization declined during the base period, the Plan may assume no change in utilization, and apply the deceleration factor to the price trend factor only.

A Plan which experiences financial hardship because of compliance with the price standard may comply with the profit limitation, or may request relief in the form of adjustments to its allowable trend factors. Financial hardship is defined as an increase in the claim cost ratio of at least 3 percentage points (in contrast to 2 percentage points in the 1979 standard) for at least three months in 1980, compared to the corresponding period in 1979, or the ability to forecast losses.

The profit limitation stipulates that a Plan's 1980 profit margin may not exceed the revenue weighted average of the best two out of three calendar years 1976, 1977, 1978, and that the 1980 dollar profits may not exceed 113.5 percent of base year (1978) profits, adjusted for any increase in volume.

The 1980 price standard has redefined base year profits. It is (1) actual base year (1978) profits or (2) the average of (a) actual base year profit and (b) the multiple of base year revenue and the weighted average of the best two out of three profit margins for the calendar years 1976, 1977, and 1978. In the 1979 standard, factor (2) of the preceeding sentence was simply base year revenue multiplied by the best two out of three profit margins.

The standard does not contain instructions on what data Plans should supply to COWPS, or what methodology Plans should use to make adjustments to their allowable trend factors when they seek relief from the price standard and profit limitation. COWPS will publish this information shortly in the Federal Register.

Plans complying with the profit limitation or requesting relief in the form of adjustments in their allowable trends must file supporting documentation with COWPS and wait 30

days before using the new trends, in contrast to the 1979 standard which generally allowed Plans to self-administer the profit limitation.

A Plan with net revenue of $250 million or more in its most recent fiscal year ending before October 2, 1979 must file a Form CO-1 (organizational structure) with COWPS by February 15, 1980 or 15 days after publication of final rules, whichever occurs later. In addition, Plans will be requested to file their inflation trend factors with COWPS. Additional information on procedural rules will be issued in question and answer form in the Federal Register shortly.

The 1980 price standard which applies to health insurers does not apply to HMOs. HMOs are expected to achieve deceleration in their premium increases because of compliance with the pay standard, professional fee standard, and the HEW limitation on hospital expenditures. HEW has not announced a 1980 standard for hospitals. The Secretary of HEW, Patricia Harris, is expected to make a major announcement shortly. In the interim, HEW expects hospitals to limit their increases in expenditures to 12.4 percent (the 1980 HEW hospital "market basket" 10.8 percent; the population adjustment factor 0.6 percent; and the intensity factor 1.0 percent).

IV. Price Advisory Committee

A six member Price Advisory Committee was appointed by the President in December 1979 to review the general price standard, profit limitation, and industry exceptions, including the exception for health insurers. The chairman is Al Sommers, chief economist of the Conference Board. Other members are Robert Atwood, a partner in the accounting firm of Deloitte, Haskins and Sells, Barbara Bergmann and John Sheaham, economics professors, Carol Greenwald, President of the National Cooperative Bank in Washington, D.C. and former Massachusetts Commissioner of Banking, and Stanley Ruttenberg, president of the consulting firm of Ruttenberg, Friedman, Kilgalon, Gutchess and Associates.

The Committee has met twice. Technical aspects of the standards, such as the effectiveness of the enforcement procedure and the appropriateness of the CPI as a measure of inflation have been discussed. Further meetings of the committee will consider items such as the impact of the liberalized wage standards on the price standards. It is too early in the Committee's deliberations for it to recommend modifications of the present price standard.

V. Wage Standard

In October 1979, the Pay Advisory Committee was formed to recommend a pay standard to COWPS for the second program year which began in October 1979. This differs from the procedure during the first year, when COWPS developed a standard with little or no input from business or labor. The Administration hoped that if a tripartite committee, consisting of representatives from business, labor, and the public, could agree upon a recommendation, each constituency would seek to abide by the standard. John Dunlop, former Labor Secretary, Harvard professor, and skilled negotiator, was chosen to accomplish this task.

The Committee has loosened the first year (October 1978-September 1979) standard. It (1) increased the number of workers who are exempt from the standard, (2) broadened the definition of tandem relationship, (3) increased the COLA inflation assumption, and (4) raised the allowable increases in the general wage standard.

The Committee expanded the low wage exemption to include units whose average wage does not exceed $5.35 per hour. Individuals earning $4.00 per hour or less continue to be exempt from the standard. (As a result of these exclusions, approximately one-third of the labor force is exempt from the wage standard.) It also broadened the definition of tandem relationships so that an employer could justify wage increases in excess of the standard to meet comparable compensation.

The Committee raised the inflation assumption for COLA formulas to 7.5 percent from 6 percent. (During the first year, COLA payments in excess of 6 percent of compensation did not count toward compliance. Thus, many employers with workers who were covered by COLAs paid increases of 10 percent and more, and were still considered in compliance with the wage standard.) The Committee believed that the change would decrease the inequity between workers with COLAs and those without COLAs. However, as long as inflation is in excess of 7.5 percent, which economists predict will prevail until the mid-1980s, employees with COLAs will still have a substantial advantage over others who do not have corresponding provisions.

Finally, the Committee agreed on a general wage standard for the second program year with a range of 7.5-9.5 percent for companies with COLA contracts, and 8.5-10.5 percent for companies without COLA contracts. The Committee expects that wage settlements will cluster about the midpoint of the range, 8.5 percent (or 9.5 percent for companies without COLA contracts). However, it expects some settlements to be under the midpoint of the range, some over the midpoint of the range, and some outside the range. Pay adjustment above the range may be subject to government review, and will be judged on the basis of productivity improvement, acute labor shortages, gross inequity or undue hardship. The Committee has recommended that collective bargaining parties and managements determining pay unilaterally consider the cost of living, ability to pay, profits, competitive conditions, productivity, labor availability, comparable compensation in other establishments, etc.

Agreement of the concept of a range, the specific numbers, and the COLA inflation assumption were arrived at after heated private discussions. Some business and public members of the Committee wanted a single number standard, similar to that which prevailed in the first year. However, some labor and public members, including Dunlop, opposed a rigid, single number because it would hamper collective bargaining without

guaranteeing compliance. Some business and public members were fearful that a range, without specific criteria to guide individual settlements, would cause the ceiling to become the floor. Some business members wanted the bottom of the range to be 6 percent. Labor members were fearful that municipal governments would use a 6 percent standard in bargaining with public employee unions. They wanted the botttom number in the range to be higher than 6 percent, and the top of the range to be a double digit number. Some business members wanted a COLA inflation assumption in excess of 7.5 percent. The comprise which was reached calls for a COLA inflation assumption of 7.5 percent and a range of 7.5-9.5 percent, rather than 6-10 percent. Some members wanted the midpoint of the range to be designated as the overall goal. Labor members were vehemently opposed to this. They compromised by stating that the Committee expects settlements to average around the midpoint, even though there will be variations between settlements.

Lane Kirkland, president of the AFL-CIO and Committeee member, said "If it (the recommendation) was any worse, they (business) wouldn't have gotten it, and if it were any better, they wouldn't have given it to us". A staff member called it "a fragile document, and that no one wanted to give another inch". He also called it a document subject to many interpretations. One Committee member expressed the opinion that the Committee's recommendation paved the way for easing the Government out of the regulation of wages because it loosened the standard and established principles for determining wages in 1980 that were consistent with the market, rather than a regulatory approach. However, another Committee member disagreed, and said that the standard limited the increases that Big Labor will seek in 1980. Another Committee member said the important point to note was that Labor did not insist on a standard in which wage increases were to equal the increase in the CPI plus increases in productivity.

The Committee's recommendation must be promulgated by COWPS before it becomes effective. COWPS was disappointed by some of the language in the recommendation. It would have liked the recommendation to specify that workers with COLA clauses should generally receive increases in the lower half of the range, 7.5-8.5 percent, and workers without COLAs should generally receive increases in the upper half of the range, 8.5-9.5 percent. It is seeking Committee support to include this criteria in the final standard, which it expects to issue shortly. If the Committee concurs with COWPS' recommendation, then the final standard will have a range of 7.5-9.5 percent, and not 7.5-9.5 percent for companies with COLAs, and 8.5-10.5 percent for companies without COLAs. However, COWPS was pleased to obtain a recommendation for a standard of less than 10 percent. In addition, it recognizes the advantage of promulgating a standard which has labor and business support, rather than one without such support.

The Committee must still determine whether a "separate and optional standard" should apply to pensions, take action on a staff recommendation regarding procedural rules, and clarify some language in the recommendation.

ECONOMIC FORECASTS FOR THE CHICAGOLAND AREA

To many of its residents, Chicago is no longer the city that works. To make matters worse, Chicago area economists are predicting that the recession predicted for 1980 will not bypass the 8-county area, because of its greater concentration of recession vulnerable producers of durable goods. Economists expect Chicago employment to decline in 1980 and unemployment to increase. According to John Coulter, Chief Economist for the Chicago Association of Commerce and Industry (CACI), "1980 will not be a good year, and the first half will be pretty bad". In contrast, 1979 was an excellent year. Many indicators, e.g. employment, personal income, the index of industrial activity, posted historic highs.

CACI has forecast that "gross metropolitan production", or the areas' output of goods and services, will decline by 0.7 percent in 1980, in contrast to a 10.5 percent increase in 1979. Unemployment is expected to average 7.3 percent in 1980, in contrast to 5.2 percent in 1979.

CACI and the Harris Bank predict more double digit inflation for Chicago in 1980. The Harris expects inflation to average 11.5 percent, and CACI expects inflation to increase "faster than the national average".

Total wages and salaries are expected to increase by 9.2 percent in 1980, despite a reduction in employment. Fringe benefits, including health insurance, are expected to increase by 10.5 percent, the largest increase in Chicago history, according to CACI.

The two strongest sectors of the economy in 1980 are expected to be commercial construction and machinery production. "That should help us avoid a precipitous plunge, as we saw in 1975", Coulter said. In addition, the printing, metals fabrication and services industries are expected to perform well in 1980. However, economists expect

the steel industry, food industry, homebuilding, and retail sales to be relatively weak.

In the long run, Thomas Coulter, Chief Executive Officer of the Chicago Chamber of Commerce (no relation to John), expects Congress to enact a tax cut in 1980 that will revamp the tax system and provide incentives to capital formation "that should lead to a capital investment boom in the decades of the 1980s, and the Chicago area will share in it".

I. Consumer Price Index for All Urban Consumers (CPI-U), U.S. city average

a. Annual and end of year increase

* The December 1978-to-December 1979 increase in the CPI (13.3 percent) was the largest in 33 years. It is also the fifth highest since the Government began compiling the statistic in 1913. Only in 1946, when wartime controls were removed, and in the war period, 1917-1919, was there more inflation than in 1979.

* The administration is predicting that the CPI-U will rise 10.4 percent in 1980. Moreover, some Administration economists privately expect the CPI to rise at a 15 percent rate in the current quarter.

* The rapid acceleration of inflation in 1979 was primarily caused by an increase in the housing (12.2 percent) and transportation (14.3 percent) components of the CPI. These two components have a weight of 62 percent in the CPI-U, (housing 43 percent, transportation 19 percent).

* Many economists believe that the CPI overstates inflation because of its treatment of home ownership costs. The Bureau of Labor Statistics, which compiles the CPI, has begun to construct alternative measures. The five experimental measures would have lowered the overall inflation figure for 1979 from 13.3 percent to between 10.8 percent and 11.2 percent.

* In 1979, the rate of increase of medical care prices was less than the all items index. Physician services and hospital and other medical care services also increased at a slower rate than the all items index.

b. November 1979-to-December 1979 change in the medical care components of the CPI-U, U.S. city average, unadjusted

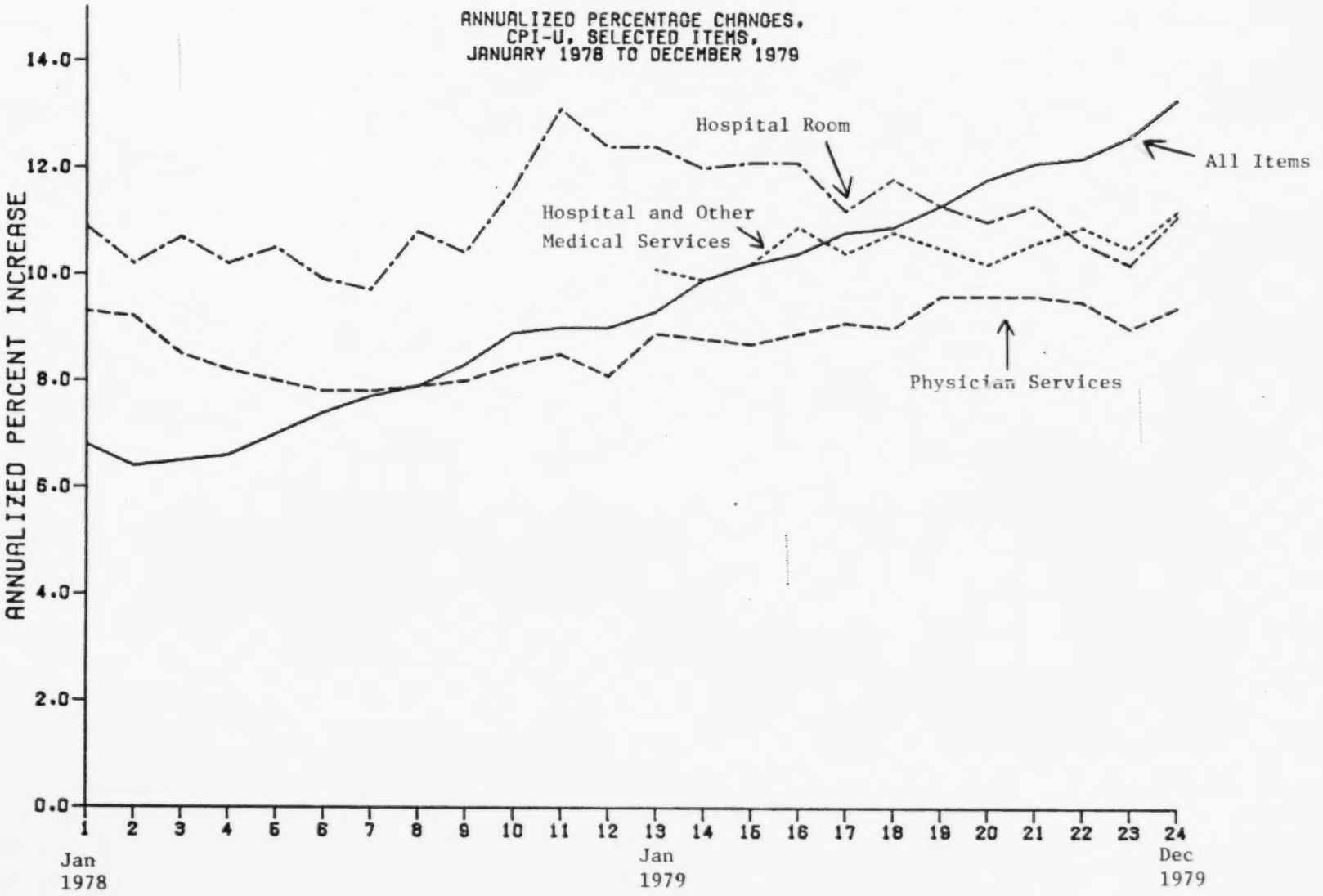
* The medical care index increased at the same rate as the all items index, 1.1 percent. The increase was higher than had been anticipated, and reflected above average increases in dental services, other professional services, and hospital and other medical care services.

* The index of dental services has increased sharply in recent months. For example, the increases in the months of December and November were 1.7 percent, and 1.0 percent respectively, in contrast to increases of 0.6 percent in each of the months of October and September, and 0.4 percent in each of the months of July and August. ADA officials said that the acceleration reflected the recent rise in gold and silver prices, as well as end of the year adjustments in dental fees.

* Other professional services increased 2.0 percent. A BLS spokesman attributed the above average increase to overhead adjustments in some smaller cities in the Northeast.

* The increase in hospital and other medical care services was 1.1 percent. This increase was above average for the month of December, and was generally attributed to an increase in hospital labor costs and some earlier than usual hospital rate adjustments.

Figure I


ANNUALIZED PERCENTAGE CHANGES,
CPI-U, SELECTED ITEMS,
JANUARY 1978 TO DECEMBER 1979
ANNUALIZED PERCENT INCREASE
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Hospital Room
All Items
Hospital and Other
Medical Services
Physician Services
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24
Jan
1978
Jan
1979
Dec
1979
MONTHS

b. AHA hospital cost and intensity indexes

* Each month the AHA publishes the Hospital Cost Index (HCI), which reflects changes in the price of a hospital market basket consisting of 46 procedures. It also publishes a hospital intensity index (HII), which reflects changes in the quantity of these same procedures. The real service volume index (RSV) adjusts the intensity index (HII) for changes in seasonally adjusted patient days. The data used in the construction of these indexes is obtained from approximately 700 hospitals. Results for the periods ending August, September and October 1979 are presented below.

Table 7
Percentage Change in Hospital Cost and Intensity Index, 1979

	Month Ending		
	August	September	October
Hospital Cost Index (HCI)	9.6	10.1r	10.6p
Hospital Intensity Index (HCI)	0.9	1.1r	1.9p
Real Service Volume (RSV)	2.2	3.0r	4.5p

r revised
p preliminary

Source: American Hospital Association

Table 3
Percent Change in the Consumer Price Index for All Urban Consumers (CPI-U), U.S. city average

	1977	1978	1979	Dec. 1978 to Dec. 1979
All items	6.5	7.7	11.3	13.3
Services	7.7	8.5	11.0	13.7
Food and Beverages	6.0	9.7	10.8	10.0
Housing	7.0	8.7	12.2	15.2
Apparel and Upkeep	4.5	3.5	4.4	5.5
Transportation	7.1	4.7	14.3	18.2
Energy	9.5	6.3	25.2	37.4
Medical Care	9.6	8.4	9.3	10.1
Physician Services	9.3	8.3	9.2	9.4
Hospital and Other Medical Care Services	NA	NA	10.7	11.2
Hospital Room	11.5	11.0	11.4	11.1

Source: Bureau of Labor Statistics

Table 4
Percent Change in the Consumer Price Index for all Urban Consumers (CPI-U), U.S. city average, unadjusted

	Dec. 1978 to Dec. 1979	Nov. 1979 to Dec. 1979	1979
All items	13.3	1.1	11.3
Medical Care	10.1	1.1	9.3
Medical Care Commodities	7.6	0.9	7.2
Medical Care Services	10.6	1.2	9.7
Professional Services	9.3	1.2	8.6
Physician Services	9.4	0.7	9.1
Dentist Services	9.7	1.7	7.8
Other Professional Services	7.4	2.0	7.6
Other Medical Services	11.8	1.1	10.8
Hospital and Other Medical Care Services	11.2	1.0	10.7
Hospital Room	11.1	1.1	11.4
Other Hospital and Medical Care Services	11.3	0.7	
Services	13.7	1.3	11.0
Services less Medical Care	14.1	1.2	11.2

Source: Bureau of Labor Statistics

c. Regional Variations in the CPI-U

* Last year's overall 13.3 percent inflation rate varied between and within regions. Prices rose most in the West, which posted a 15.4 percent overall price rise. Inflation was the most moderate in the Northeast, where the index climbed 11.8 percent. Inflation in the North Central region increased at a 13.7 percent rate, and in the South at a 12.8 percent rate.

* Annual increases in the all items index and medical care costs for various metropolitan areas is presented below. Only the cities which were sampled in December are included.

Table 5
Percent Charge in CPI-U, Selected Cities,

	Dec. 1978-to-Dec. 1979		Annual average	
	All Items	Medical Care	All Items	Medical Care
Atlanta	12.3	9.2	10.4	6.7
Buffalo	10.8	6.7	9.5	7.4
Chicago-Northwest Indiana	15.0	10.8	12.5	8.8
Cleveland	13.0	8.5	13.2	6.7
Dallas-Fort Worth	16.1	6.7	12.7	5.6
Detroit	15.3	11.1	11.0	9.0
Honolulu	12.3	6.8	11.1	8.0
Houston	13.2	10.5	13.2	9.6
Kansas City	17.6	11.6	14.3	12.3
Los Angeles-Long Beach-Anaheim	15.7	10.9	10.8	10.2
Minneapolis-St. Paul	12.2	11.1	11.5	8.3
New York-Northeastern New Jersey	10.6	7.2	8.7	7.9
Philadelphia	11.2	9.3	9.9	8.2
Pittsburg	11.7	10.9	11.2	10.7
San Francisco-Oakland	14.8	11.0	8.5	9.2

Source: Bureau of Labor Statistics

II. Other indicators of changes in hospital costs and utilization

a. Panel Survey

* The AHA publishes information on changes in hospital costs and utilization which it obtains from the National Panel Survery, a monthly survey of 1,760 comunity hospitals representing a cross section of the industry. Results for October, the latest month for which information is available, appear in Table 6.

* According to the AHA, if the rate of inflation had remained at 6.6 percent, the rate that prevailed when the VE was formed, community hospital expenses in October 1979, would have increased 13.0 percent, and expenses in the first 10 months of 1979 would have increased 11.7 percent, a rate consistent with the VE goal.

* The hospital industry is feeling the impact of inflation. Hospital expenses increased 15.1 percent in October 1979. This rapid growth reflected sharp increases in both labor and nonlabor costs. However, data for October showed several signs of cost containment effort. For example, bed capacity decreased for the first time in more than 8 years, personnel increased at a below average rate, and the growth of depreciation and interest expenses continued to moderate.

* Admisions increased 2.6 percent in the first 10 months of 1979, compared to only 0.7 percent in the corresponding period of of 1978. Faster growth of utilization is due primarily to use of hospitals by the under-65 population.

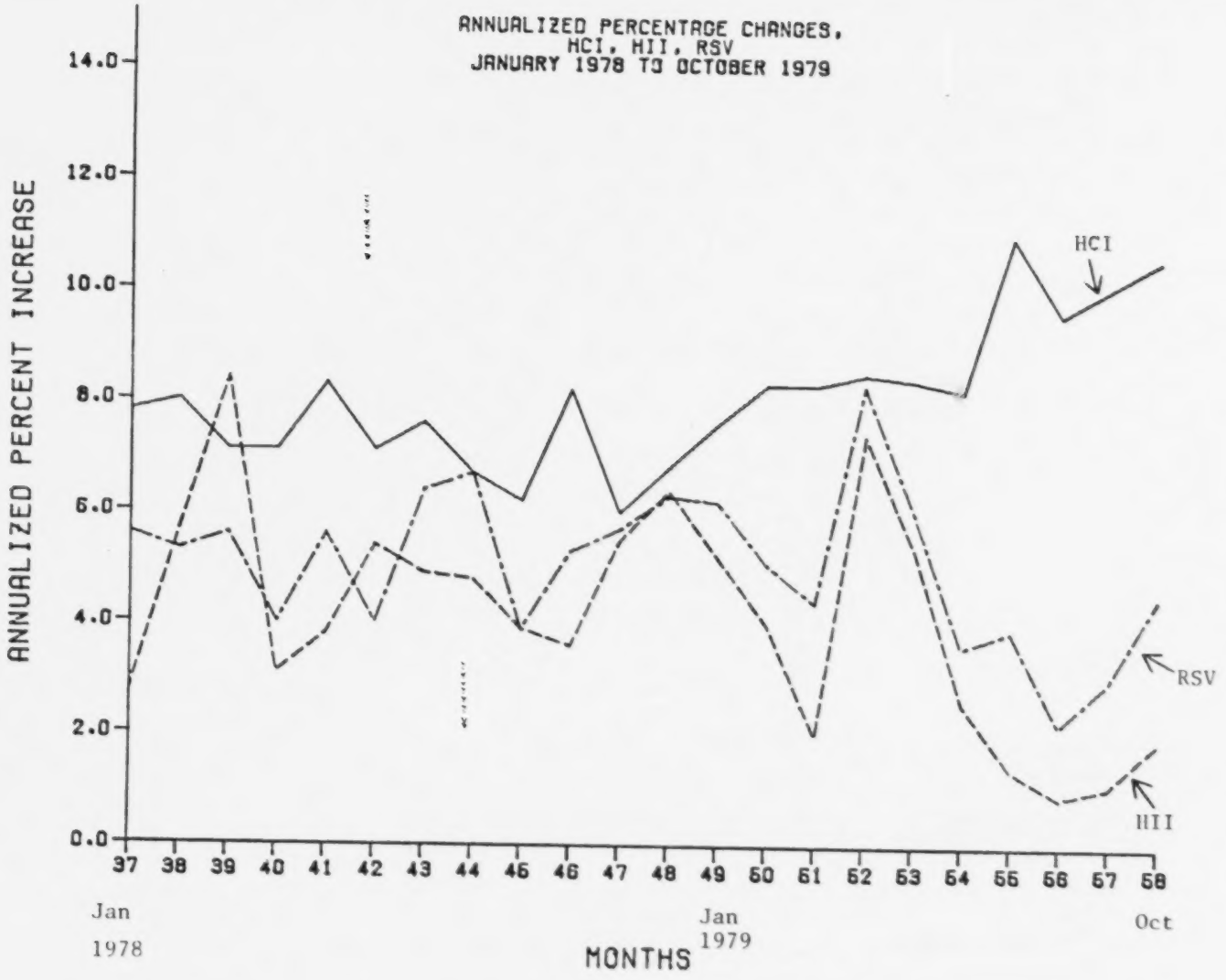
* In October, surgical operations increased at a significantly above average rate, 6.8 percent, and births continued to increase at a faster rate than in 1978, 3.0 percent vs. 1.0 percent.

Table 6
Percentage Change in Community Hospital Costs and Utilization

	12 Month Period ending October		Year-to-date 10 Mos. 1978 to 10 Months 1979	Month of October 1978 to October 1979
	1977-1978	1978-1979		
Total Expenses	13.1	13.2	13.4	15.1
Total Revenue	13.3	13.5	13.8	16.7
Admissions	1.0	2.0	2.6	2.8
Inpatient Days	0.5	1.1	1.5	2.5
Outpatient Visits	2.1	-0.8	-0.4	4.6
65-and-over Admissions	5.6	4.5	5.0	7.2
65-and-over Inpatient Days	3.6	2.8	2.9	6.2
65-and-over Length of Stay	-1.8	-1.6	-1.9	-0.9
Under 65 Admisssions	-0.5	1.1	1.7	1.2
Under 65 Inpatient Days	-1.4	0.1	0.6	0.2
Under 65 Length of Stay	-0.9	-1.1	-1.1	-1.0

Source: American Hospital Associations, Office of Policy Studies, TRENDS, January 1980.

Figure II


ANNUALIZED PERCENTAGE CHANGES,
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JANUARY 1978 TO OCTOBER 1979
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6.0
4.0
2.0
0.0
HCI
RSV
HII
37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58
Jan
1978
Jan
1979
Oct
MONTHS

The Economic Report is a publication of the Health Economics Research Department of the Blue Cross and Blue Shield Associations; Edward S. Mills, Vice President.

For information on Economic Forecasts of Inflation, Medical Care Costs and Hospital Utilization, 1980 Price and Wage Standards for Plans, Economic Forecasts for the Chicagoland Area, and Inflation Report contact Dr. Rachel Golden, Research Economist, (312) 440-5539. Other requests, contact Linda M. Krasovskis, Editorial Assistant, (312) 440-5671.

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A 3500 - 1

Blue Cross
Association
Blue Shield
Association

840 North Lake Shore Drive
Chicago, Illinois 60611
312/440-6000

March 20, 1980

TO: Chief Plan Executives

FROM: Edward S. Mills, Vice President, Health Economics Research

SUBJECT: Economic Report

IN THIS ISSUE

- Physician Reimbursement Study: Analysis of Claims Experience, Medical Mutual of Cleveland, Inc.
- General State of the Economy
- Rules for Complying with Pay and Price Standards
- Impact of Charge in Mandatory Retirement on Employment
- Inflation Report:

  CPI-U (end of year, one month change, regional variations)
  AHA Panel Survey
  AHA Hospital Cost and Intensity Indexes
  Employment Cost Index
  Unemployment Rates for Ten Largest States

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PHYSICIAN REIMBURSEMENT STUDY
ANALYSIS OF CLAIMS EXPERIENCE
MEDICAL MUTUAL OF CLEVELAND, INC.

EXECUTIVE SUMMARY

Health Economics Research at the national associations has been developing new approaches to analyzing Plan experience in a comprehensive way. The focus has been on applications beneficial to marketing, actuarial research, utilization review, and other functional areas.

As a part of this effort, Health Economics Research staff have developed the Cost Containment Monitoring System (CCMS). This is a comprehensive indexing system developed to identify actual and potential Plan liabilities. Aberrant trends in physician charges, Plan allowances, and service utilization rates, for any segment of the business, are identified at aggregated and detailed levels. All of these elements are then combined to analyze changes in benefit expenditures and intensity changes. These areas are crucial in explaining where the benefit dollar is going and in anticipating future policy and coverage requirements.

Initial work has centered on the analysis of account specific experience. The CCMS has identifed variations in utilization rates by plant location age category, and other variables. The results of these analyses will be used in presentations to various accounts.

* * *

PHYSICIAN REIMBURSEMENT STUDY

ANALYSIS OF CLAIMS EXPERIENCE

MEDICAL MUTUAL OF CLEVELAND, INC.

The Economic Report of September, 1979 included some of the initial results from the Physician Reimbursement Study, and described some of the account specific analyses provided by Health Economics Research staff for Blue Shield of Maryland. This article will review the applications and analytic potential of the study and also describe some of the results recently provided for Medical Mutual of Cleveland, Inc.

The Physician Reimbursement Study (PRS) has been incorporated within the Product Study domain in terms of our National Association's work scheme. Initial activities included the solicitation and acquisition of the participation of a group of Blue Shield Plans. Once this was obtained, there was the extensive job of data extraction from the paid claims history files in the Plans, and the compilation of a health research data base. This activity is well underway. When completed, the resulting data base will provide a comprehensive source of health payment information to be used for analytic purposes, nationally and at the local level.

Much of the effort within health research focuses on cost containment and, as an aid in this direction, Health Economics Research staff have worked toward the development and refinement of a computerized evaluation system termed the Cost Containment Monitoring System. This has taken the form of a comprehensive indexing system consisting of a series of price and quantity indexes, a value index and an "ideal" index. A true utilization index is also

calculated by adjusting the quantity indexes for contract changes. As mentioned in the previous report, the focus of the analytic work has been on the identification of aberrant trends in the following major categories:

1. Prices
2. Allowances
3. Utilization
4. Expenditures

The research data base and our analytic tools can address these pertinent cost categories at any level of an account's experience. The work completed for Medical Mutual of Cleveland, Incorporated, focused on the experience of two large automotive firms and one of the large ferrous metals accounts.

A particularly useful capability of the Cost Containment Monitoring System (CCMS) has been in the evaluation of trends in Plan benefit expenditures, which are a function, of course, of changes in price and changes in utilization of services. Price times quantity is equal to dollar expenditures and with appropriate price and quantity indexes being calculated within the CCMS, indexes of benefit expenditures are easily produced.

The usefulness of these indexes lies in the ability to identify the relative contribution of price and quantity changes to overall expenditure changes. Exhibits I through III of the attachments illustrate this particular application. These Exhibits pertaining to physician specialties, reflect experience taken from the combined data of the three Cleveland accounts. Exhibit I displays the trend in Plan allowances for anesthesiologists and

radiologists over the four years, 1973 through 1976. Over that time span, allowances increased by about 52 percent for anesthesiologists, and by only 22 percent for radiologists. Exhibit II displays a reverse pattern for the two specialist categories. In terms of utilization or quantities of services rendered, the radiologists exhibit quantity increases in the order of almost 50 percent while the anesthesiologists show a decline of approximately 20 percent. The noteworthy aspect of this comparison is the wider divergence in frequency of service rendered between the two specialty groups. The allowance comparison does not show the same degree of divergence. Exhibit III then carries the analysis one step further to show the effect on benefit expenditures of this greater service utilization change. The expenditure index for radiologists reaches a level of about 200 by 1976, indicating a doubling in the amount of benefit expenditures. This may be compared to an increase of only about 40 percent for the anesthesiologists. The example shows clearly the greater influence of the utilization increase for radiologists in terms of Plan liabilities.

Another application of the CCMS has been in the identification of major intensity shifts. This analytic capability is a by-product of the indexing system. Such shifts can be easily spotted by observing the difference between the fixed and variable based charge indexes of the system. Using the combined experience of the three accounts at Medical Mutual of Cleveland, Inc., a comparison was first made of the percentage distribution of dollars charged by type of service between 1973 and 1976. Exhibit IV shows this comparison. It can be noted that the major shift has been away from surgery and into the medical type of service. One may be prompted to look at the nature of the change for one or both of these broad categories. In this example, the

medical type of service will be examined to determine the degree of service mix change that has occurred over the four years. It can be seen from Exhibit V that the two psychotherapy procedures are accounting for a larger share of the pie in 1976. In 1973 they account for 47 percent of the medical dollars charged and by 1976 they accounted for 58 percent. In 1974 a state law was passed in Ohio mandating payment for psychiatric care rendered by licensed psychologists, and staff at Medical Mutual of Cleveland had been aware of a general tendency toward greater use of psychotherapy services. The PRS data confirmed this tendency. Again, this kind of analysis could be performed for any subgroup of the business, such as a county location or for a physician specialty.

Exhibit VI is included to show the wide disparity in utilization for three major counties in the Cleveland area. Cuyahoga county experienced a 41 percent utilization increase, while Ashtabula experienced a 45 percent decline.

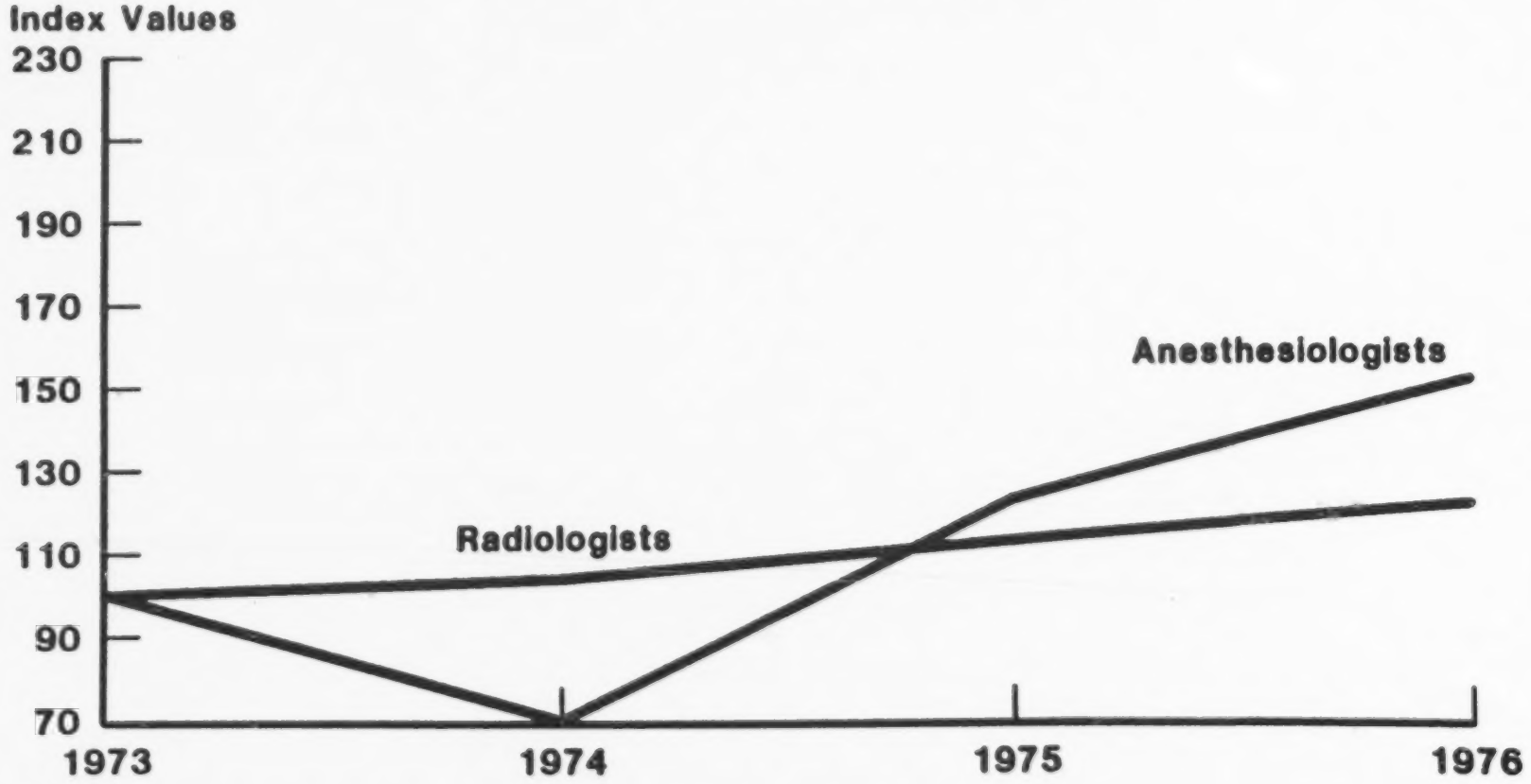
Another pertinent utilization comparison is displayed in Exhibit VII, showing major age classifications. The experience seems to reflect expected patterns of utilization inasmuch as the higher rates of change show up for the older age groups.

These comparisons are intended to provide a sampling of the kind of analyses that can be undertaken through an application of the Cost Containment Monitoring System. New techniques are being added to the system and subsequent developments will be featured in the coming months.

EXHIBIT I

MEDICAL MUTUAL OF CLEVELAND, INC.
NATIONAL ACCOUNT EXPERIENCE*

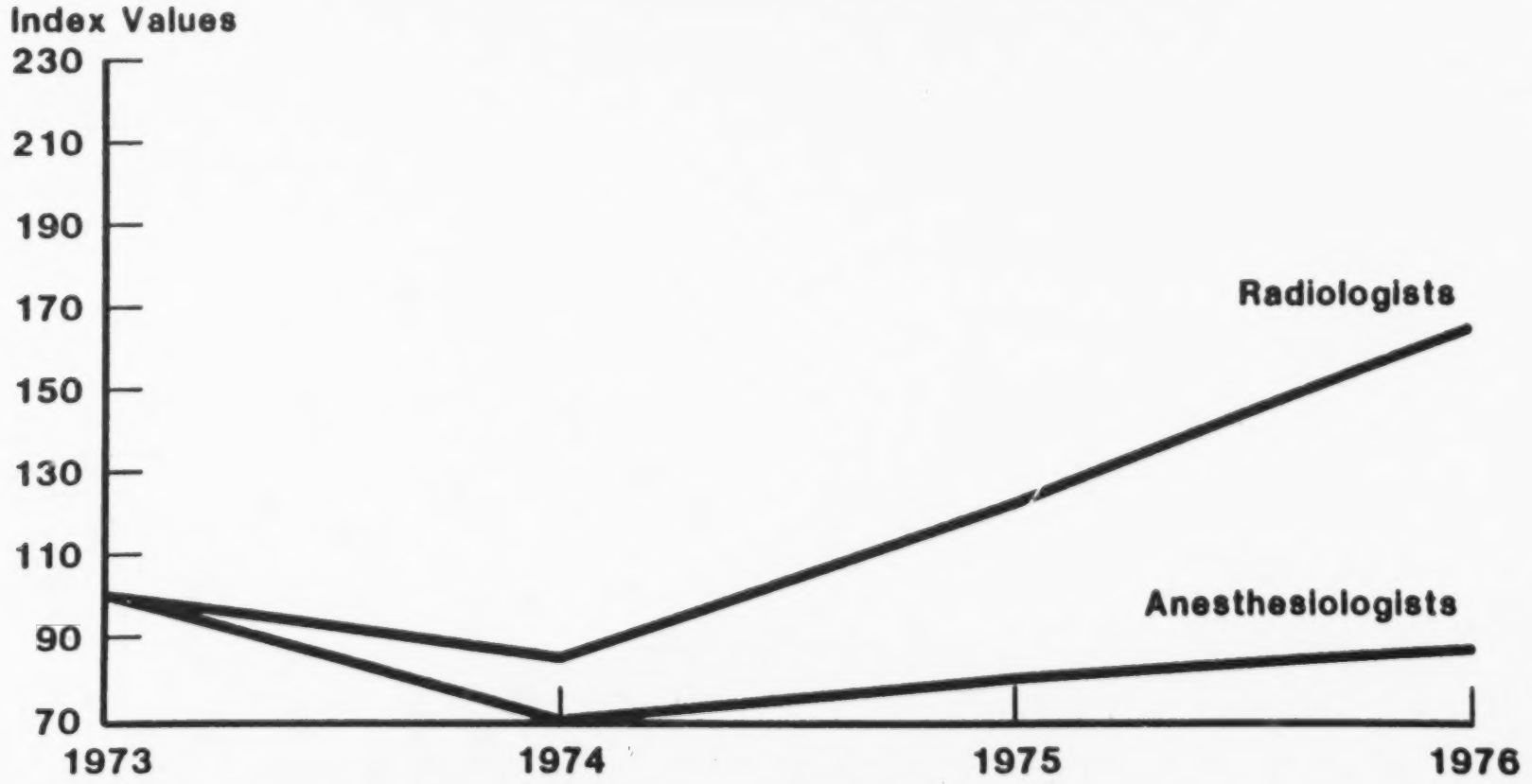
ALLOWANCE INDEXES
ANESTHESIOLOGISTS VS. RADIOLOGISTS



*Includes two automotive accounts and a ferrous metal account

MEDICAL MUTUAL OF CLEVELAND, INC.
NATIONAL ACCOUNT EXPERIENCE*

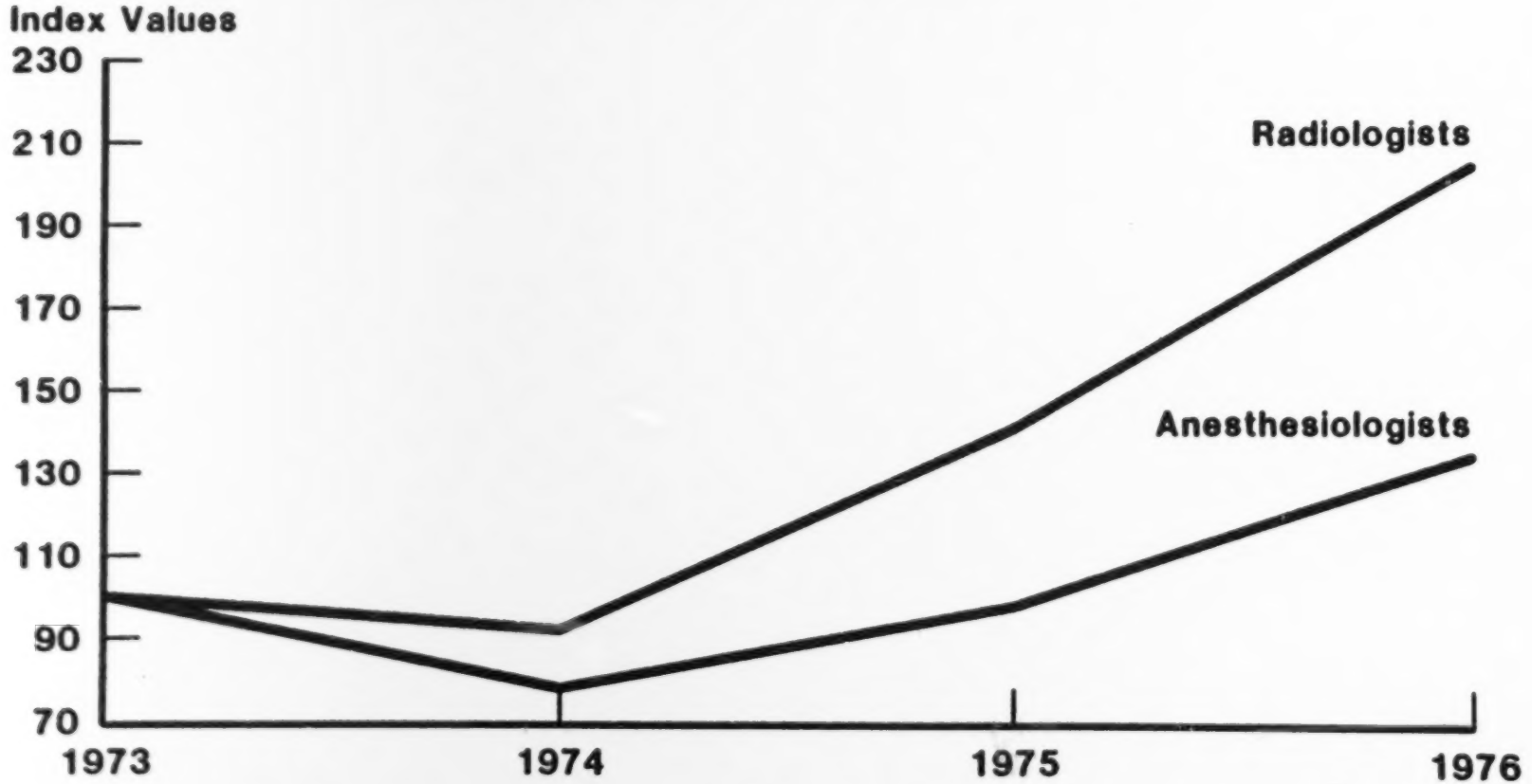
QUANTITY INDEXES
ANESTHESIOLOGISTS VS. RADIOLOGISTS



*Includes two automotive accounts and a ferrous metal account

MEDICAL MUTUAL OF CLEVELAND, INC.
NATIONAL ACCOUNT EXPERIENCE*

EXPENDITURE INDEXES
ANESTHESIOLOGISTS VS. RADIOLOGISTS

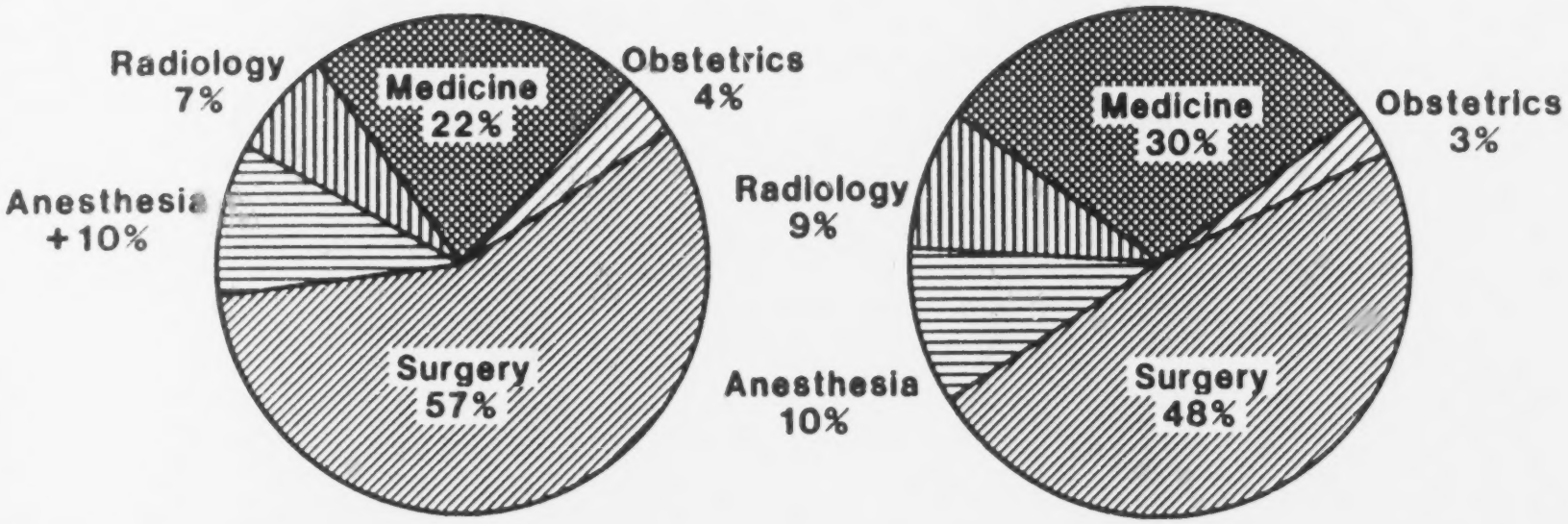


*Includes two automotive accounts and a ferrous metal account

EXHIBIT IV

MEDICAL MUTUAL OF CLEVELAND, INC.
NATIONAL ACCOUNT EXPERIENCE*

PERCENTAGE DISTRIBUTION OF DOLLARS CHARGED** BY TYPE OF SERVICE
1973 VS 1976



*Includes two automotive accounts and a ferrous metal account

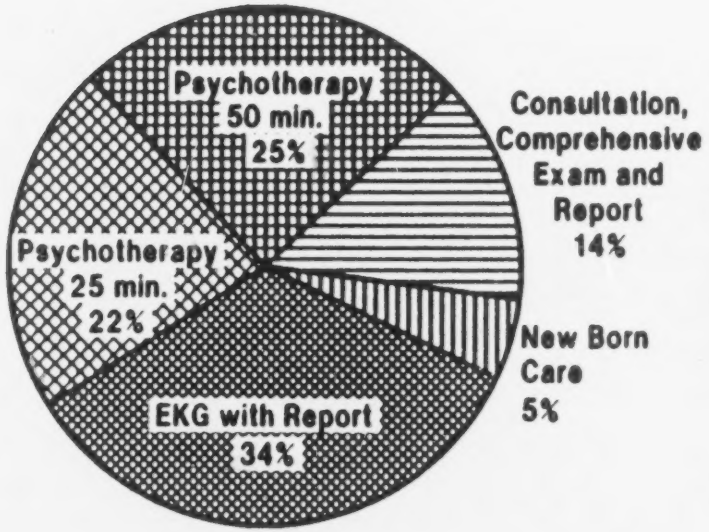
**Based upon procedures included in the study

EXHIBIT V

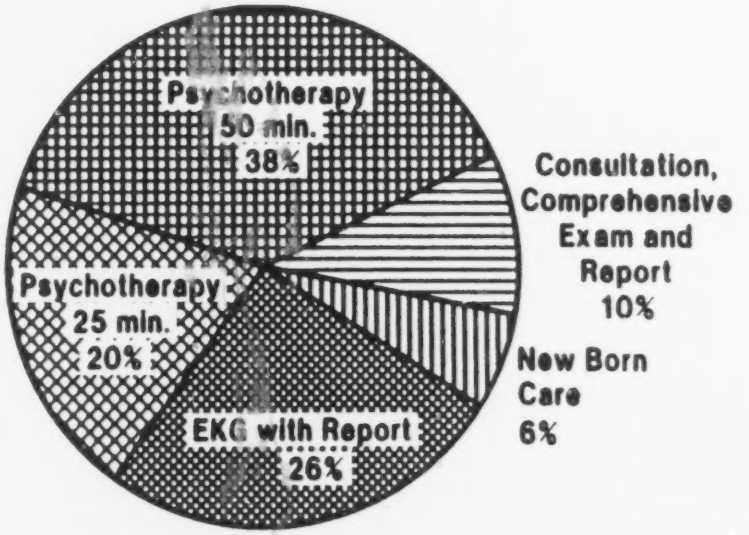
MEDICAL MUTUAL OF CLEVELAND, INC.
NATIONAL ACCOUNT EXPERIENCE*

PERCENTAGE DISTRIBUTION OF DOLLARS CHARGED** BY PROCEDURE WITHIN THE MEDICAL TYPE OF SERVICE 1973 VS 1976

1973



1976

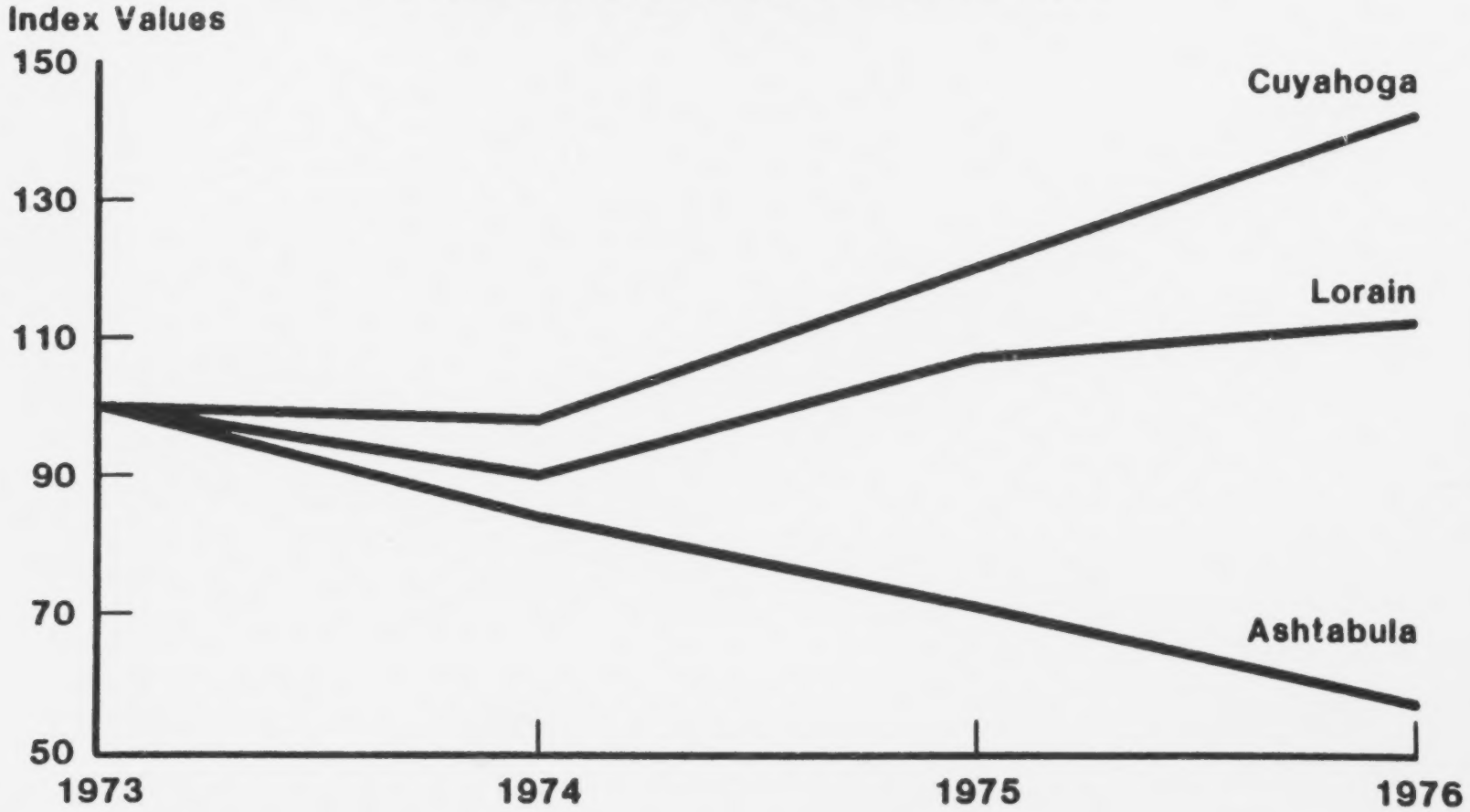


*Includes two automotive accounts and a ferrous metal account

**Based upon procedures included in the study

MEDICAL MUTUAL OF CLEVELAND, INC.
NATIONAL ACCOUNT EXPERIENCE*

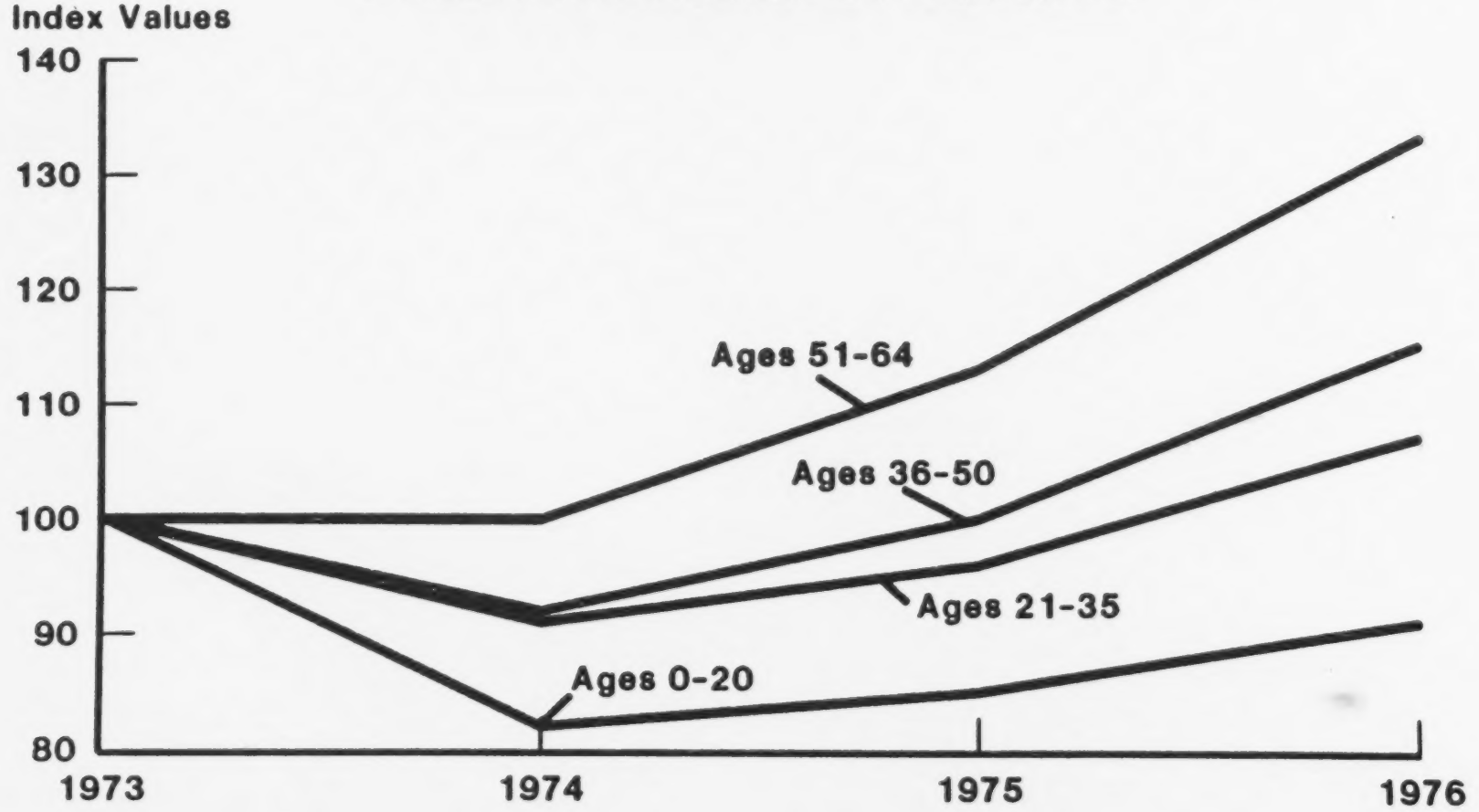
UTILIZATION INDEXES BY COUNTY



*Includes two automotive accounts and a ferrous metal account

MEDICAL MUTUAL OF CLEVELAND, INC.
NATIONAL ACCOUNT EXPERIENCE*

UTILIZATION INDEXES BY AGE GROUP



*!Includes two automotive accounts and a ferrous metal account

GENERAL STATE OF THE ECONOMY

INTRODUCTION

In January, the President submitted a budget for FY 1981 (the twelve month period beginning in October, 1980) which projected a deficit of $16 billion. In addition, the Congressional Budget Office (CBO) raised its estimate of the FY 1980 deficit to $47 billion. The public and the financial markets concluded that the fiscal policy which was incorporated in these budgets was stimulative, rather than restrictive, and would cause inflation to accelerate, rather than decelerate.

Inflation was accelerating. The underlying inflation rate, which excludes "volatile" prices such as energy, food, and housing, rose at an annual rate of 10 percent in January, the latest month for which information is available, compared to 8.6 percent in the fourth quarter of 1979, and 7.9 percent in the third quarter of 1979. In February, the producer price index increased at an annual rate of 19.6 percent.

The bond market collapsed in response to the inflationary momentum, losing about $200 billion in market value in 7 weeks. Although economists continued to forecast a mild recession in 1980, the economic expansion showed unexpected durability. Its strength was largely attributed to inflationary expectations, which were causing consumers and businesses to spend in spite of record high interest rates and record low personal savings rates.

The continued strength of the economy and rapid inflation induced an increase in demand for financing. However, since long-term interest rates were rising sharply, business increased its dependence on the short-term credit markets. The result was turmoil in the money market, as short-term rates rose rapidly to unprecedented levels. For example, between February 15th and March 19th, the prime rate rose 6 times, from 15 1/4 percent to 19 percent.

Throughout January, February, and March, inflationary expectations grew. However, wage increases were moderate in view of the marked rise in the CPI. (Average wages and salaries increased 8.7 percent in 1979 vs. a 13.9 percent increase in the CPI from January, 1979 to January, 1980.) Robert Russell, Director of the Council on Wage and Price Stability, told the Joint Economic Committee that it was "problematical" whether wages would "continue to be so remarkably well behaved" in light of continued price rises.

Many people in both the public and private sectors became extremely concerned about the nation's economic problems -- high inflation, high interest rates, low productivity, low capital formation, and low savings. Economists warned their clients of the possibility of a financial collapse or a boom and then bust. (See Memorandum to Chief Plan Executives dated March 13, 1980.) While the symptoms of the inflation were evident, no one knew of a painless cure. In addition, there was no consensus on a course of action. For example, some economists, businessmen, and politicians called for mandatory price, wage, and credit controls as a necessary first step to cure inflation. The polls showed that the public supported controls. However, the President and other economists and businessmen pointed out that mandatory controls had never worked in

the past, resulted in a misallocation of resources, and caused greater inflation once the controls were lifted. The President said that he would not impose mandatory price and wage controls.

In response to the deteriorating inflationary situation, the President announced a new anti-inflation program on March 14th. The program focused on five major issues:

1. A balanced budget for FY 1981
2. Credit curbs
3. Voluntary wage and price standards
4. Energy
5. Structural changes

The President's Program to Restrain Inflation

1. Balanced budget - The heart of the President's program is a reduction in total spending of $2 billion in the current fiscal year, and another $13 billion in FY 1981, bringing the budget into balance. Balancing the budget is to be achieved by additional taxes, imposing withholding on interest and dividends, faster "tax-bracket creep" resulting from steeper inflation, and reduced government spending. The areas in which there will be a decrease in spending will be announced in late March.
2. Credit curbs - The President exercised his power to give the Federal Reserve the authority to restrict credit card lending, checking account overdrafts and increases in the assets of money market mutual funds. This is to be achieved by requiring certain lenders to maintain idle cash

balances against certain types of loans. In addition, the Fed imposed a 3 percentage point surcharge on the 13 percent discount rate for large banks that borrow frequently at the discount window. (This will substantially increase the cost of new funds.) The Fed also asked banks to voluntarily apply credit controls and hold increases in loans to 9 percent this year, about half the rate of the increase in business loans at major New York City banks since the start of the year. Housing, automobile, and consumer durable loans were deliberately excluded from the array of credit curbs.

3. Voluntary wage and price standards - A 7 1/2 percent to 9 1/2 percent pay standard became effective for the twelve months which began in October 1979. Price monitoring will be extended to companies with sales of $100 million or more. Previously, only companies with sales of $250 million or more had been required to file regular reports. The COWP's staff will be enlarged to enable it to monitor the standards more extensively and to study the problem sectors of the economy.

4. Energy - To reduce the nation's dependence on foreign oil and to raise additional revenue by $10 billion, import fees are to be imposed on crude oil and gasoline. This will raise the price of gasoline 10 cents per gallon at the pump.

5. Structural changes - The President said that structural changes are needed to increase productivity, and thus permanently restrain inflation, rather than moderate it temporarily. However, he said that these changes, which include a tax cut for business and regulatory reform, would be implemented after the budget was balanced.

Anticipated Result: More Inflation, Sharper Recession, No Increase In Productivity

The President's program is designed to dampen inflationary expectations by submitting a balanced budget to convince the public and the financial markets that the President is serious about containing inflation. It is also intended to induce a recession by tightening monetary policy. However, it is too early to tell whether the Federal Reserve will slow the growth of the money supply, and make money tight, as well as expensive. (There are some concerns that the Fed may tighten money too much and cause a rash of bankruptcies.) The market system is successful in modifying behavior patterns. But it takes time to work. Thus, no "quick fixes" to the inflation problem are anticipated.

Despite the noble goals of the President's program, it appears that his program will:

1. contribute to inflation in the short run by increasing interest rates and gasoline prices. (The increase in the CPI will create more inflation as indexed wages and pensions are automatically raised.)
2. cause the recession to start sooner (probably in the second quarter) and be more severe than previously had been anticipated, and
3. discourage capital formation and research, which is needed to increase productivity.

Impact on Plans

* Higher borrowing costs, reduced availability of credit, and accelerated corporate tax payments, which will decrease corporate cash flow, are likely to cause accounts to put pressure on Plans to contain premium increases, document cost containment activities, and provide alternative methods of financing.
* There will be an increase in the number of companies, particularly small and medium sized, going into bankruptcy as a result of the curbs on borrowing and high interest rates.
* The recession is likely to produce higher unemployment than was forecast earlier. In past recessions, the health care sector was asked to respond to the needs of workers who were temporarily unemployed and lacked health insurance coverage. Blue Cross and Blue Shield Plans should begin to plan as a system to meet this problem.
* FEP enrollment may decline due to the President's announcement that federal employment will be reduced 1 percent (20,000 employees) by year end.
* The average American family has at least two people working. Since the majority of workers are covered by employer provided health benefit plans, many families have overlapping coverage. A further squeeze on real income and curbs on consumer borrowing is likely to induce some families, particularly those who are young and healthy, to reevaluate their health benefit plans in light of current cash needs.
* Health care benefit plans which offer tax saving advantages, i.e., cover "normal" health care expenditures, can be expected to be of increasing importance as the number of families paying higher marginal taxes increases due to inflation.

* Plans' reserves are not likely to grow as fast in 1980 as in 1979. Although investment income will increase, inflation will cause Plans' administrative expenses and claim costs to increase as well. In addition, competitive pressures, as well as the 1980 price standard for health insurers, will restrain increases in premiums.
* Some companies may seek to restrain their premium increases by reducing the health benefits they provide their workers.
* Energy, defense, high technology and export industries are not expected to be affected by a recession as much as the construction, automobile, steel, and consumer durable goods industries, small businesses and farmers.
* The West, Mountain States, and Southwest, are expected to be less affected by the recession than the North and East.
* Life insurance companies expect the new credit curbs to increase the number of their low-cost policy holder loans, and thus depress their profitability.

RULES FOR COMPLYING WITH PAY AND PRICE STANDARDS

Second Year Pay Standard

Up until the morning of its March 10th meeting, the Pay Advisory Committee expected COWPS to announce a pay standard which would reflect the Committee's January 22nd recommendation. (See January ECONOMIC REPORT.) In fact, several members of the Committee were irate that the new pay standard had already not been issued. However, at the last minute, plans were changed, and Alfred Kahn, chairman of COWPS, announced that since the President was reviewing the anti-inflation program, he (Kahn) did not want to pre-empt the President.

The pay standard, reflecting the Committee's recommendation, was issued on March 13th. (For a copy of the standard, see Federal Register dated March 18th.) The standard limits wage increases to 7 1/2 to 9 1/2 percent for the period October 1979 through September 1980. A 1 percentage point "catch up" for companies without COLAs is permissible. See January ECONOMIC REPORT. Businesses with 1,000 or more employees that settle upon wage contracts in excess of 8 1/2 percent are requested to report that information immediately to COWPS, along with supporting documents.

In addition, reporting requirements for the second program year's pay standard were tightened. Companies with 5,000 or more employees are requested to file semi-annual pay reports, in contrast to the first year's rules which only required companies with 10,000 or more employees to report. Companies with

1,000 or more employees requesting "exceptions" still must notify COWPS. In addition, COWPS still expects companies with revenues of $250 million or more to file quarterly pay reports.

The issue of an alternative standard for pensions is still on the Pay Advisory Committee's agenda. The joint Management and Labor staffs of the Committee met March 11th to consider the recommendation. The meeting was short, and no recommendation was forthcoming.

Impact of the new pay standard on the price standard

On March 12th, the Price Advisory Committee issued an interim report which indicated that once the new pay standard becomes effective, the price standard should be adjusted to maintain the same relationship between the two parts of the program. For example, an 8 1/2 percent pay standard (the mid-point of the range) should allow businesses to increase prices 0.5 percentage points more than they did in 1976 and 1977. The current standard requires businesses to hold price increases for the two years ending this October to the same percentage increase that occurred for 1976 and 1977. However, there is no indication that COWPS intends to change the price standard adopted last fall.

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Rules for Plan Compliance with the Price Standard

The President has indicated that monitoring of the price standard will be increased in an effort to restrain inflation. On March 3rd, interim final procedural rules for compliance with the price standard for health insurers were issued by COWPS. According to these rules, by March 31, 1980, Plans with revenues of at least $250 million in their last fiscal year ending before October 2, 1979 are requested to supply COWPS with the following information:

1. the inflation trend factors used during the first program year, i.e., in use on April 1, July 1, and October 1, 1978 or the percentage increase in claims costs used to compute the base period inflation trend factors,
2. any changes in base period trend factors adopted during the first program year,
3. the decelerated trend factor(s) in effect at the beginning of the first program year and the trend factor(s) in effect on December 1, 1979,
4. the base period factors for the second program year (which may be the same as 1 above), and
5. the trend factor(s) that will be in effect for the entire second program year, as of January 1, 1980.

COWPS is anxious that Plans be accountable for changes from the generally applicable standard. Thus, it has requested that Plans making adjustments to their inflation trend factors (an exception to the general standard), supply it with:

1. base period inflation trend factors,
2. the maximum inflation trend factors permitted during 1980,
3. the proposed inflation trend factors, and
4. a demonstration that for the effected product lines, the ratio of A to B exceeds 1.0, where "A" is the percentage increase (net of the effect of benefit changes) in per capita claims costs for a period in calendar year 1980 of not less than 3 months (and ending not more than 3 months prior to the date of submission immediately preceding the request) over the per capita claims cost for a corresponding period one year earlier, and "B" is the percentage increase (net of benefit changes) in per capita claims costs for the corresponding period (as in "A" above) ending in 1978 over the par capita claims costs for the same calendar period one year earlier.

The rules also clarify the maximum allowable adjustment to inflation trend factors. In the question-and-answer section, it is stated that the maximum amount of a compliance unit's inflation trend factor under the exception to the general price standard is the percentage by which "A" exceeds "B" multiplied by the unadjusted trend factor.

IMPACT OF CHANGE IN MANDATORY RETIREMENT ON EMPLOYMENT

The mandatory retirement age was raised last year from 65 to 70 years. Since then, Plan actuaries, marketing personnel, and others have been concerned about the impact of the higher retirement age on employment patterns and practices in order to ascertain demand for carve-out programs. Recently, the Bureau of National Affairs and the American Society of Personnel Administration conducted a survey. According to the survey, the higher retirement age has not resulted in a significant increase in the number of workers between ages 65 and 69.

Of the 267 employers who responded to the survey, 21 percent experienced an increase in the number of workers staying beyond normal retirement age, and in many cases the increases were minimal. About 52 percent of the respondents made arrangements for some employees to stay on as consultants, while 62 percent indicated that they occassionally recalled retirees for temporary assignment when special skills or manpower was needed.

Nevertheless, the legislation which raised the retirement age, the increase in the proportion of the labor force of retirement age, and the impact of inflation on a retiree's fixed income, have led many companies to review their retirement practices.

Sixty percent of the companies responding to the survey indicated that they have made, or are in the process of making, changes in their retirement practices; and over half the anticipated changes involved adding or expanding pre-retirement planning and counselling services for their employees. (Thirty-six percent of the respondents already have pre-retirement counselling.)

Respondents to the survey included employers in manufacturing and other business, health care, education, and government.

INFLATION REPORT

Consumer Price Index for All Urban Consumers, U.S. city average, unadjusted

a. December 1979 to January 1980. (See Tables 1 and 2.)

* The All Items index increased 1.4 percent, or at a compound annual growth rate of 18.2 percent. This was the largest monthly increase since August 1973.

* The underlying rate of inflation, which excludes "volatile" prices such as energy, food, and housing, rose at an annual rate of 10 percent in January, compared to 8.6 percent in the fourth quarter of 1979, and 7.9 percent in the third quarter of 1979.

* Almost 75 percent of the January increase in the All Items Index could be traced to the rise in gasoline prices.

* Housing costs, which have a weight of approximately 40 percent in the index, continued to contribute to the overall increase, jumping 1.5 percent in the month of January.

* The Medical Care index increased 1.3 percent, while the All Items index increased 1.4 percent. Increases in Medical Care have been equal to or below increases in All Items since February 1979.

* Physician services increased 1.4 percent, in contrast to 0.7 percent in December, and 0.4 percent in November. However, many physicians periodically revise their fees in the month of January.

* Dental services increased 1.3 percent in January, in contrast to 1.7 percent in December, and 1.0 percent in November. The January 1980 increase in dental services reflected beginning of the year adjustments in labor costs, as well as higher prices for gold and silver.

* Hospital and other medical services increased 1.5 percent, in contrast to a 1.0 percent increase in December, and a 1.1 percent increase in November. Approximately 30 percent of the hospitals revise their fee schedules in January each year. However, the BLS spreads this increase over a two month period. Higher silver prices, which caused the price of radiology to increase at above average rates, and the nursing shortage, which continued to put upward pressure on hospital labor costs, contributed to the January increase.

b. January 1979 to January 1980. (See Tables 1 and 2.)

* The All Items increased 13.9 percent, or 4.6 percentage points more than in the 12 month period ending January 1979.

* Medical care increased 10.1 percent, or 3.8 percentage points less than the All Items index. The increase for the 12 months ending in January 1980 was 0.9 percentage points greater than in the 12 month period ending in January 1979.

c. Forecasts for 1980

* The increase in the underlying rate of inflation (10 percent annual rate for January) has caused the Congressional Budget Office (CBO) to revise its 1980 CPI forecast. The CBO currently expects the CPI to increase 10.6-12.6 percent between the fourth quarter of 1979 and the fourth quarter of 1980. In January, it forecast an increase of 8.6-11.6 percent for this same period.

* Robert Russell, Director of the Council on Wage and Price Stability, said in a speech to the National Economics Club, that he expects the increase in the CPI in 1980 to be close to the 13.3 percent rate experienced between December 1979 and December 1979, and to remain at double digit levels "throughout the 1980s".

* Some economists are predicting that the CPI will increase at an annual rate in excess of 20 percent in February and March due to (1) higher food prices, resulting from the floods in California and a draught in the Midwest, (2) higher mortgage interest rates, resulting from the three month suspension of state mortgage rate ceilings, and (3) new rounds of anticipatory price increases by business.

Figure 1

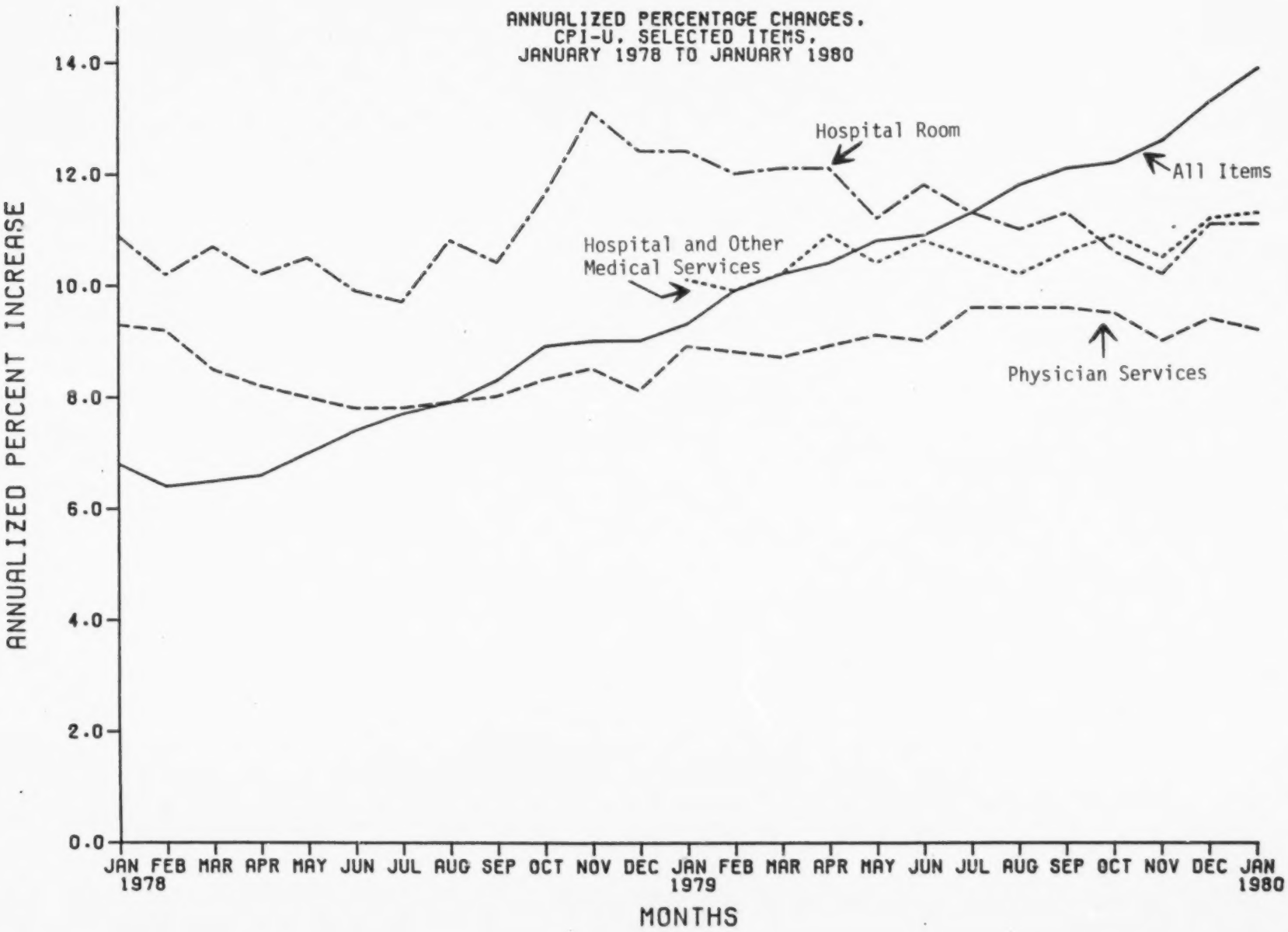

ANNUALIZED PERCENTAGE CHANGES.
CPI-U. SELECTED ITEMS.
JANUARY 1978 TO JANUARY 1980
ANNUALIZED PERCENT INCREASE
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Hospital Room
All Items
Hospital and Other
Medical Services
Physician Services
JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC JAN
1978
1979
1980
MONTHS

Table 1
Percentage Change in the Consumer Price Index for All Urban Consumers (CPI-U), U.S. city average, unadjusted

	Jan. 1979 to Jan. 1980	Dec. 1979 to Jan. 1980
All Items	13.9	1.4
Food and Beverages	8.8	0.8
Housing	16.0	1.5
Apparel and Upkeep	6.4	-0.7
Transportation	20.4	2.5
Medical Care	10.1	1.3
Entertainment	7.1	1.0
Commodities	13.6	1.4
Services	14.5	1.5
Energy*	41.6	4.5

* Energy is a special CPI index and includes elements from several of the major categories.

Source: Bureau of Labor Statistics

Table 2
Percentage Change in the CPI-U for Medical Care, U.S. city average, unadjusted

	Dec. 1979 to Jan. 1980	Dec. 1978 to Jan. 1979	Jan. 1979 to Jan. 1980	Jan. 1978 to Jan. 1979
Medical Care	1.3	1.3	10.1	9.2
Medical Care Commodities	0.8	0.5	7.9	7.2
Medical Care Services	1.4	1.4	10.5	9.6
Professional Services	1.3	0.7	9.0	8.6
Physician Services	1.4	1.6	9.2	8.9
Dental Services	1.3	1.6	9.4	8.4
Other Professional Services	1.3	1.0	7.7	7.7
Other Medical Care Services	1.5	1.4	11.9	10.7
Hospital and Other Care Medical Services	1.5	1.1	11.3	11.1
Hospital Room	1.5	1.5	11.1	12.4
Other Hospital and Medical Care Services	1.5	1.3	11.5	10.0
Service less Medical Care	1.6	0.8	14.9	9.4

Source: Bureau of Labor Statistics

Table 3
Percentage Change in the
CPI-U, U.S. city average and selected areas

	Nov. 1979 to Jan. 1980		Jan. 1979 to Jan. 1980	
	All Items	Medical Care	All Items	Medical Care
U.S. city average	2.5	2.4	13.9	10.1
Anchorage, Al.	2.1	5.2	10.1	8.2
Baltimore, Md.	3.2	1.0	14.8	11.1
Boston, Ma.	2.1	3.0	12.7	11.0
Chicago, Il. - N.W. Ind.	1.9	5.5	15.3	11.3
Cincinnati, Oh. - Ky. - In.	2.6	3.8	13.4	7.0
Denver - Boulder, Co.	0.6	4.5	14.4	13.2
Detroit, Mi.	2.6	3.3	15.7	8.8
Los Angeles - Long Beach - Anaheim, Ca.	3.7	2.2	16.5	10.0
Miami, Fl.	3.3	3.2	13.2	14.3
Milwaukee, Wi.	2.9	2.6	17.8	10.9
New York - Northeastern NJ.	2.2	2.0	11.4	9.4
Northeast, Pa. (Scranton)	2.0	3.6	12.1	10.7
Philadelphia, Pa.	2.2	2.0	12.3	9.2
Portland, Or.	3.4	2.6	15.5	11.2
St. Louis, Mo.	3.1	5.7	14.4	13.3
San Diego, Ca.	2.5	0.5	18.2	8.2
Seattle - Everett, Wa.	3.7	4.0	16.8	12.2
Washington, D.C. - Md. - Va.	2.9	1.0	11.1	9.4

Source: Bureau of Labor Statistics

Indicators of Hospital cost and utilization

a. National Hospital Panel Survey of expenses and utilization (See Table 4.)

According to the National Hospital Panel Survey, the increase in community hospital expenses in November, 1979 was more moderate than in October, 1979 (14.7 percent vs. 15.1 percent), but was higher than the growth rate for November, 1978 (12.8 percent), or the average rate of increase for the first 11 months of 1979 (13.5 percent). Factors contributing to the November increase in hospital expenses were increases in wage rates (due to cost-of-living adjustments and higher salaries for nurses), higher prices for hospital supplies, (energy, malpractice, insurance, capital), and increased utilization.

If the CPI had increased at the same rate in 1979 as in the fourth quarter of 1977, when the VE was formed, i.e., 6.6. percent, hospital expenses in November would have increased 12.2 percent (rather than the 14.7 percent increase actually experienced), and expenses in the first 11 months of 1979 would have increased 11.8 percent (rather than the 13.5 percent increase actually experienced).

The National Hospital Panel Survey reported that the accelerating trend for hospital utilization experienced during the first 10 months of 1979 continued in November. Admissions increased 2.8 percent in November, 1979, compared to -0.6 percent in November, 1978, and inpatient days, births and outpatient visits increased at rates 1 to 4 percentage points higher than in November, 1978. The increase in births accounted for

approximately 38 percent of the increase in under-65 admissions, although the growth rate of surgical operations decreased. Occupancy rose to 74.3 percent in November, 1979, the highest occupancy rate for any November since 1974.

Despite higher wages and supply costs, costs per unit of service increased at a slower rate than last year.

Table 4
Percent Change in Community Hospital Cost and Utilization

	12 Month Period Ending November		Month of Nov. 1978 to Month of Nov. 1979
	1978	1979	
Total Expenses	13.0	13.3	14.7
Inpatient Expenses/Admission	11.7	10.6	11.8
Inpatient Expenses/Inpatient Day	12.2	11.6	11.9
Utilization			
Admissions	0.7	2.3	2.8
Inpatient Days	0.3	1.4	2.7
Average Length of Stay	-0.4	-0.9	-0.1
Outpatient Visits	1.4	-0.8	-0.2
Adjusted Admissions	1.2	2.5	2.6
Adjusted Patient Days	0.8	1.6	2.6
Surgical Operations	0.9	4.0	2.7
Births	0.3	4.7	4.7
65 and Over Admissions	5.3	4.8	6.2
65 and Over Inpatient Days	3.8	2.8	3.6
65 and Over Length of Stay	-1.4	-1.9	-2.4
Under 65 Admissions	-0.8	1.4	1.5
Under 65 Inpatient Days	-1.8	0.6	2.1
Under 65 Length of Stay	-1.0	-0.9	0.6

Source: American Hospital Association, Office of Policy Studies, HOSPITAL PERFORMANCE, February 1980,, pp. 12, 14.

b. AHA hospital cost and intensity indexes (See Table 5.)

Each month the AHA publishes the Hospital Cost Index (HCI), which reflects changes in the price of a hospital market basket consisting of 46 procedures. It also publishes a hospital intensity index (HII), which reflects changes in the quantity of these same procedures. The real service volume index (RSV) adjusts the intensity index (HII) for changes in seasonally adjusted patient days. The data used in the construction of these indexes is obtained from approximately 700 community hospitals. Results for the 12 month periods ending October, November and December 1979 are presented below.

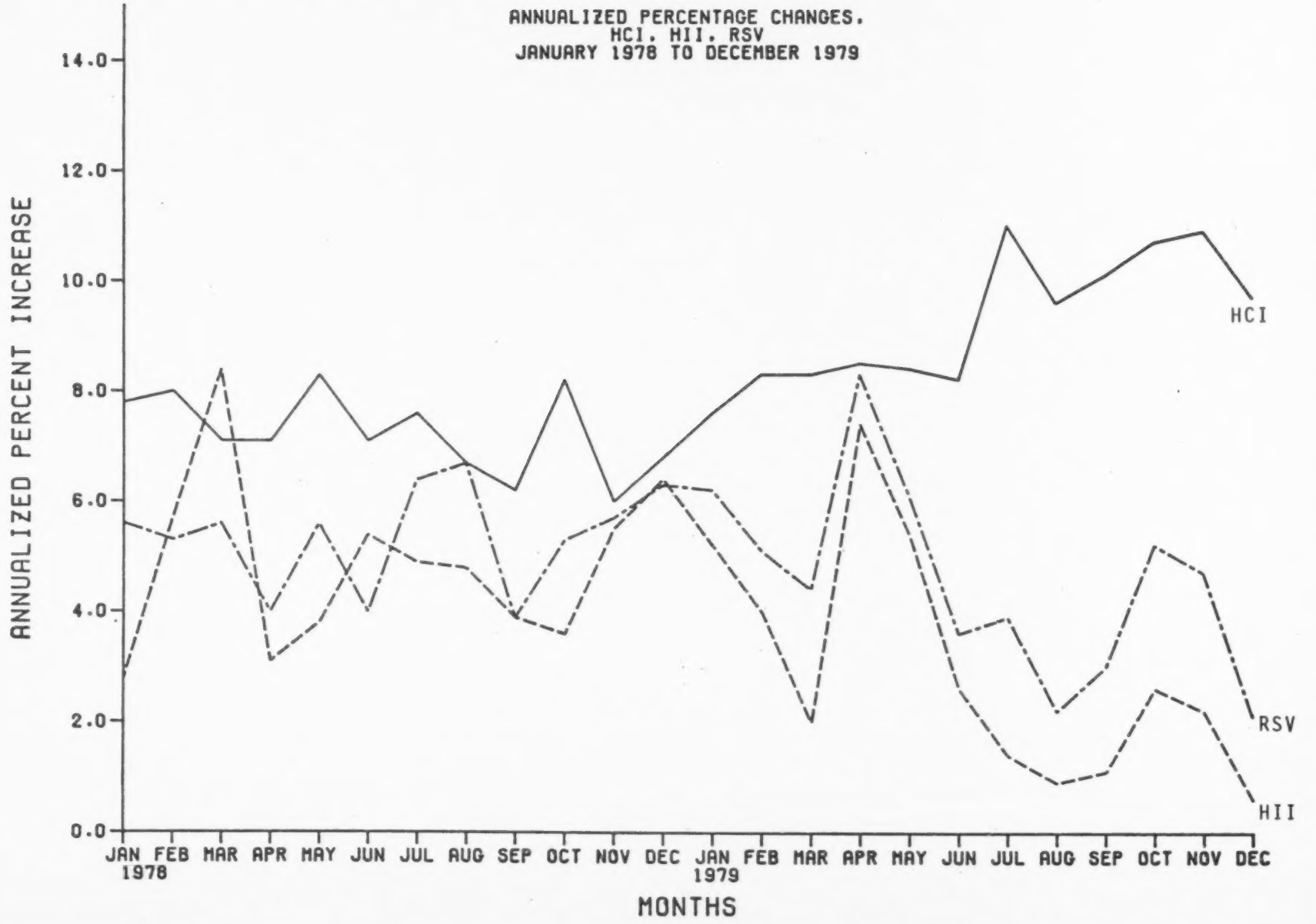
Table 5
Percentage Change in Hospital Cost and Intensity Index, 1979

	12 Month Period Ending		
	October	November	December
Hospital Cost Index (HCI)	10.7	10.9	9.7
Hospital Intensity Index (HII)	2.6	2.2	0.6
Real Service Volume (RSV)	5.2	4.7	2.1

r. revised
p. preliminary

Source: American Hospital Association

Figure 2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RSV
HII
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1978
1979
MONTHS

III. Employment and earnings

a. Employment Cost Index. (See Table 6.)

For the 12 month period ending in December 1979, wages and salaries (excluding overtime and fringe benefits) increased 8.7 percent, the highest rate of increase since the employment cost index was introduced in 1975. Among industry groups, pay gains ranged from 7.2 percent in construction to 13.2 percent in finance, insurance, and real estate (a group largely influenced by fluctuations in commission earnings for sales workers).

Pay of unionized workers increase more rapidly than non-unionized workers (9.0 percent vs. 8.5 percent). Pay advances for blue-collar workers average 9.0 percent over the year, compared with 8.6 percent for white-collar workers, and 7.2 percent for service workers.

Pay increases were greatest in the North Central region (9.4 percent), and lowest in the Northeast (7.3 percent). In the West and South, pay increased by 8.5 percent.

Table 6
Percent Change In Employment Cost Index

	3 Months Ended	12 Months Ended			
	December 1979	March 1979	June 1979	September 1979	December 1979
All private nonfarm workers	2.4	7.8	7.6	7.7	8.7
Workers, by occupational group					
White-collar workers	2.4	7.0	7.0	7.4	8.6
Professional and technical workers	2.8	7.1	6.8	7.5	8.8
Managers and administrators	1.4	7.2	6.9	7.6	7.4
Sales workers	3.9	7.9	6.7	4.8	8.8
Clerical workers	2.1	7.4	7.4	8.5	9.4
Blue-collar workers	2.5	8.3	8.4	8.4	9.0
Craft and Kindred workers	1.9	8.5	8.2	8.3	8.6
Operatives, except transport	3.1	7.8	8.6	8.3	9.2
Transport equipment operatives	2.4	9.3	8.3	9.5	10.2
Nonfarm laborers	2.9	7.9	8.6	8.5	9.1
Service workers	1.8	8.3	7.2	5.9	7.2
Workers, by industry division					
Manufacturing	3.1	8.0	8.2	8.1	8.6
Durables	3.3	8.4	8.2	8.4	9.0
Nondurables	2.7	7.4	8.2	7.6	7.8
Nonmanufacturing	2.0	7.6	7.2	7.5	8.8
Construction	1.1	7.9	7.6	7.2	7.2
Transportation and public utilities	2.0	8.9	8.4	9.2	9.4
Wholesale and retail trade	1.3	7.3	7.0	7.7	7.9

Table 6 (Continued)
Percent Change In Employment Cost Index

	3 Months Ended	12 Months Ended			
	December 1979	March 1979	June 1979	September 1979	December 1979
Wholesale trade	2.1	6.6	7.7	7.8	7.9
Retail trade	1.0	7.6	6.7	7.7	7.9
Finance, insurance, and real estate	4.3	*	*	*	13.2
Services	2.5	7.0	6.4	6.6	8.5
Workers, by region					
Northeast	2.1	6.8	6.9	6.9	7.3
South	2.4	8.8	8.3	7.7	8.5
North Central	2.6	7.5	7.8	8.2	9.4
West	1.8	7.9	7.7	8.2	8.5
Workers, by bargaining status					
Union	2.6	8.2	8.3	8.4	9.0
Manufacturing	3.4	8.7	9.1	8.6	9.4
Nonmanufacturing	1.7	7.7	7.6	8.2	8.5
Nonunion	2.3	7.5	7.2	7.3	8.5
Manufacturing	2.7	7.3	7.4	7.7	7.9
Nonmanufacturing	2.1	7.6	7.1	7.1	8.8
Workers, by area					
Metropolitan areas	2.5	7.8	7.7	7.9	8.9
Other areas	1.9	7.6	7.4	7.3	7.9

* Not available

Source: Bureau of Labor Statistics

b. Employment situation

Total employment in February was close to 98 million for the third consecutive month. Since February 1979, employment has grown by 1.5 million, the smallest over-the-year change in more than 4 years. The unemployment rate for February was 6.0 percent, compared with a January rate of 6.2 percent.

Nonfarm payroll employment has grown by 2 million since February 1979. In February 1979, employment gains were concentrated in the service-producing sector. The biggest increase was in trade (110,000), and services (60,000). Over the past year, jobs in trade increased by 475,000 and in services by 700,000.

Overall, employment in manufacturing was little changed in February, although there were offsetting movements among components. Almost all major manufacturing industries -- with the notable exception of capital goods -- reported fewer people on payrolls than a year ago.

Table 7
Employment status of the noninstitutional population
for the ten largest States*

Number in Thousands

State and employment status	Seasonally adjusted					
	Feb. 1979	Oct. 1979	Nov. 1979	Dec. 1979	Jan. 1980	Feb. 1980
California						
Unemployment rate	6.3	6.3	6.1	6.2	5.8	6.1
Florida						
Unemployment rate	5.9	5.9	5.6	5.4	5.1	5.2
Illinois						
Unemployment rate	5.1	5.8	5.9	6.4	7.1	7.0
Massachusetts						
Unemployment rate	5.7	5.5	5.3	5.6	5.0	4.8
Michigan						
Unemployment rate	7.2	8.5	8.2	8.7	9.5	10.3
New Jersey						
Unemployment rate	7.5	6.9	7.0	6.5	6.9	5.4
New York						
Unemployment rate	6.8	7.2	7.0	7.3	7.7	7.6
Ohio						
Unemployment rate	6.6	6.3	5.8	5.8	6.3	6.1
Pennsylvania						
Unemployment rate	6.5	8.0	7.3	7.1	7.2	6.8
Texas						
Unemployment rate	4.2	4.0	4.2	3.9	4.8	4.9

* These are the official Bureau of Labor Statistics' estimates used in the administration of Federal fund allocation programs.

Source: Bureau of Labor Statistics

The Economic Report is a publication of the Health Economics Research Department of the Blue Cross and Blue Shield Associations; Edward S. Mills, Vice President.

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Association
Blue Shield
Association

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April/May 1980

TO: Chief Plan Executives

FROM: Edward S. Mills, Vice President, Health Economics Research

SUBJECT: Economic Report

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o Current Medical Care Price, Utilization and Cost Statistics

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EXECUTIVE SUMMARY

IMPACT OF RECESSION ON PLANS

Economists generally agree that the recession is here, even though certain industries and regions, e.g., the automobile and steel industries in the midwest, the lumber mills in Oregon, and the construction industry in the South, have been affected more than others. It is too early to tell whether the recession will be severe and V-shaped, i.e., comparable to the 1973-75 recession (the worst since the Great Depression), mild, i.e., comparable to the "saucer" recessions of 1969-70 and 1960-61, or L-shaped, i.e., with a period of prolonged stagnation. Nevertheless, economists tend to agree that a period of high unemployment, high inflation and sluggish growth lies ahead.

WHAT DOES THIS MEAN FOR PLANS?

- The combination of declining employment, weak corporate profits, and moderate growth in money is likely to have a negative impact on Plan enrollment and revenue to the extent that a large portion of contracts are in the manufacturing sector (other than in industries such as autos where covered benefits for terminated employees continue for substantial periods after employment ends) or construction. Major collective bargaining agreements will be renegotiated this year, which will probably result in some improvement in health benefits. However, only a small portion of the work force will be affected by these negotiations.

- Higher unemployment and a reduction in hours worked may tend to increase Plan utilization. Moreover, the rate of increase of medical care prices is not likely to decelerate because inflation, as measured by the underlying rate (changes in the cost of factors of production), is not expected to decline. Thus, claim cost trends are likely to accelerate. Plans which cannot respond quickly and pass on increased costs to subscribers may experience underwriting losses in 1980 and 1981. However, Plans which can quickly pass increased costs on to subscribers may not be harmed by (and in the case of cost-plus and ASO arrangements may even benefit financially in the short run from) the increase in utilization. Nevertheless, in the long run everyone loses by high claim costs.

- Mandatory wage and price controls probably will not be imposed during a recession. However, there will be more monitoring of the voluntary price standards for the health care sector -- health insurers, physicians, and hospitals.

- Analysts expect short-term interest rates to be lower by year-end, and credit controls to be lifted. However, the Federal Reserve Board is not expected to abandon its attempt to fight inflation and is not expected to increase the money supply so as to force feed an economy which has been slimmed down by high unemployment. Investment income will probably be lower in 1980 than in 1979.

- Congress will probably remain in a conservative mood. Legislators are unlikely to add new social programs, including catastrophic health insurance, which increase the deficit or government regulation.

RECENT TRENDS IN SURGERY UTILIZATION

In this Economic Report are findings of surveys of recent surgery utilization trends among Blue Cross and Blue Shield Plan subscribers and the Federal Employee Program (FEP). This study grew out of the Voluntary Effort's National Steering Committee's concern, voiced at its October 1979 meeting, about the effects of overall surgery utilization growth on total hospital utilization growth; and particularly whether elective surgery was an important factor in these trends. One of the principal findings is surgery utilization for 26 procedures for FEP and Blue Cross and Blue Shield Plan subscribers declined slightly, while the AHA Panel Survey utilization for all surgery increased significantly between the first halves of 1978 and 1979. The other major finding is elective surgery trends are not significantly different from total surgery trends for FEP and Blue Cross and Blue Shield Plan subscribers.

Current Medical Care Prices, Utilization, and Costs

In April, the economy veered toward a potentially severe recession, while inflation appeared unlikely to recede much below a 10 percent annual rate. The CPI for April increased 0.9 percent, seasonally adjusted, or at a 10.8 percent annual rate before compounding. The CPI increased 1.4 percent, or at a 16.8 percent annual rate, in each of the year's first three months. In April, medical care prices increased at a slower rate than the All Items index (0.7 percent, seasonally adjusted). Some economists predict that the monthly rate of increase of the CPI will be 0.5-0.8 percent shortly.

The latest AHA Panel Survey data reveal that hospital utilization increased sharply in the first two months of 1980 primarily because of the increase in admissions of persons age 65 and over. This increase was attributed to the influenza epidemic, which was more severe than in 1979. Outpatient visits also increase, reversing the 1979 trend.

IMPACT OF RECESSION ON PLANS

Economists generally agree that the recession has arrived. It is too early to tell whether the recession (which is expected to end in mid 1981) will be severe, i.e. comparable to the 1973-75 recession (the worst since the Great Depression), or mild, i.e. comparable to the "saucer" recessions of 1969-70 and 1960-61. However, unemployment is climbing rapidly. Almost 275,000 automobile workers and 15,000 steel workers have been laid off. In addition, sizeable lay-offs have occurred in the farm equipment and tire industries. Construction employment has declined by about 7 percent since January. Agricultural economists are predicting that farmers' income will decline by 25 percent in 1980. Meanwhile, bankruptcies have soared because of tight credit and high interest rates. In April, the number of bankruptcies in Illinois was 250 percent greater than 12 months earlier.

One measure of Plan performance is enrollment, or market share. Recessions generally result in a sharp reduction in manufacturing employment, where Plans have a large percentage of their contracts. However, Plan enrollment will not decline as rapidly as employment because some manufacturers, particularly in industries with strong unions, continue to provide health coverage for their terminated workers for up to one year. The impact of unemployment on Plans is further reduced by the fact that Plan policies contain conversion rights which permit employees whose employer-provided policies are terminated to retain coverage on an individual basis. (The coverage which results from the exercise of conversion rights will not offset the reduction in coverage generated by

employer-provided policies. For example, in the last recession, a substantial number of terminated employees did not exercise their conversion privileges because they expected to be re-employed shortly or were members of multi-worker families; and some of those that did exercise their conversion privileges down-graded their policies, e.g. retaining hospital coverage but dropping or reducing medical-surgical coverage.) Thus, while Plan enrollment is likely to weaken during the recession, enrollment will not drop as rapidly as employment.

Another measure of Plan performance is financial viability. Even if Plan enrollment were to decline, subscription income might increase if rates were to increase or benefits were to expand. However, because of the political and economic climate during a recession, state insurance commissioners may delay or reduce requests for rate increases. In addition, corporations may be reluctant to expand health benefits when their profits are weak, their need for cash is greater and they do not feel the need to improve employee morale. (See Table 1 for projected changes in corporate profits.) Thus, it is possible that Plan subscription income will decline during the recession.

Table 1

PROJECTIONS OF PERCENTAGE CHANGE IN CORPORATE PROFITS

	1980	1981
All manufacturing	-9	10
Iron, steel	-18	---
Nonferrous metals	-19	-10
Electrical machinery	-10	- 2
Nonelectrical machinery	-12	- 2
Motor vehicles	-75	130
Fabricated metals	-16	---
Stone, glass	-10	-15
Chemicals	- 9	12
Paper	-25	- 8
Printing, publishing	-10	17
Oil, coal	16	20
Textile products	-15	2
Food, beverage	3	3
Rubber, plastics	-30	6

Source: Merrill Lynch Economics Inc. The figures were obtained from an outlook paper for corporate clients of the economics unit, and reproduced in the Wall Street Journal, May 14, 1980, p. 39.

In addition, interest rates generally decline during a recession and may reduce investment income. Meanwhile, Plan expenses continue to rise as a result of higher utilization and "sticky" medical care prices. Thus, the recession will adversely affect Plans by putting downward pressure on income without a concomitant decline in expenses.

I. Impact of recession on enrollment

Employment in the goods producing sector generally declines during a recession, particularly in manufacturing, where Plans have a large percent of their contracts, and construction. Employment in the service sector -- services, banks and insurance companies, retailing and other white collar industries -- often continues to increase during an economic downturn, and some economists expect this pattern to continue in 1980-81. See Table 2. However, an increasing number of economists are forecasting lay-offs in the service sector. This is because consumer spending is expected to decline. Such a reduction in spending can be traced to a sharp drop in real income and a high debt burden.

Table 2

FORECAST OF PERCENTAGE CHANGE
IN EMPLOYMENT AND POPULATION

	1979	1980e	1981e
Total nonfarm employment	3.10	1.34	1.50
Manufacturing employment	1.17	-2.03	-1.23
Nonmanufacturing employment	3.45	2.37	2.29
Population	0.72	0.96	0.99

Source: U.S. Chamber of Commerce, U.S. Regional Forecast, April 1980. The Chamber is predicting a mild recession.

Employment in the automobile and construction related industries has already declined sharply. Approximately 275,000 automobile workers and 57,000 primary metal workers have been laid off, and employment in the construction industry

has declined by about 335,000 since January. Despite the sharp decline in interest rates since March, economists predict a further decline in economic activity in industries related to the automobile, steel and construction industries. The industries affected include lumber and wood products, fabricated and primary metals, rubber and plastics, furniture and fixtures and stone, clay and glass. Approximately 12,000 lumber workers in Oregon have been laid off. Other industries have been declining for some time and are expected to continue to do so during the recession. These include steel, textiles, apparel and leather, which have been affected by increased import competition, a slowdown in demand and obsolete capital equipment. At the end of March, there were 37,000 fewer steelmaking jobs than in June, 1979. Some analysts are predicting that the number of steel jobs temporarily lost could swell to 60,000 later this year. (The rule-of-thumb is 5,000 steel jobs per 1 million ton decline in shipments.) High interest rates and a severe credit crunch have caused farmers to cut back on purchases of seed, fertilizer and farm equipment. In addition, U. S. exports are expected to decline because of the slowdown in economic activity by our major trading partners (Western European nations and Japan).

On the other hand, defense oriented industries (aerospace, instruments, electrical machinery and computers), industries related to energy development and retooling and machine tools for the automotive industry (to produce small size cars) are not expected to be hurt by the recession. In most parts of the country, engineers, computer programmers, systems analysts and electronic technicians are in short supply.

The impact of the recession will be felt differently across the nation. For example, states and metropolitan areas with a heavy concentration of non-energy and non-defense manufacturing and construction will be more severely affected than regions with large concentrations of their labor force in the service sector or in defense and energy-related industries. Moreover, states and metropolitan areas with newer plant and equipment and lower production costs are likely to be less affected than areas with older or obsolete plant and equipment. The recession is expected to affect all regions of the country. However, the highly industrialized regions -- East South Central, East North Central and Middle Atlantic -- are expected to be the most severely affected since the bulk of their economic activity is concentrated in the declining industries. See Table 3.

Table 3

U.S. REGIONAL OUTLOOK: PERCENTAGE CHANGE IN NONFARM EMPLOYMENT

	Manufacturing		Nonmanufacturing	
	1980	1981	1980	1981
United States	-2.0	-1.2	2.4	2.3
New England	-1.2	-1.3	2.3	2.0
South Atlantic	-0.8	-0.8	2.6	2.6
Middle Atlantic	-2.5	-2.6	1.0	0.9
East North Central	-5.4	-2.5	2.0	1.8
East South Central	-2.4	N/A	1.9	N/A
West North Central	-1.9	-1.0	2.2	2.0
West South Central	0.6	0.9	3.5	3.3
Mountain	1.2	0.7	3.7	3.8
Pacific	1.1	0.6	3.1	3.0

Source: U.S. Chamber of Commerce, U.S. Regional Forecast, April 1980. The Chamber is predicting a mild recession.

Nevertheless, some states and metropolitan areas within each region are expected to be more susceptible to high unemployment than others. For example, in the last recession, New Hampshire and Massachusetts experienced above-average unemployment. Both states have low rates of unemployment today, and their rates are not expected to increase sharply this year because of the large share of their manufacturing that is in the defense and high technology industries. (Defense spending declined during the last recession.) Illinois experienced below average unemployment in the last recession. However, it is expected to experience above average unemployment in the 1980-81 recession, and to lose more manufacturing jobs in the recession than it will regain as the economy snaps back.

The recession is expected to end by mid 1981. However, economists expect the recovery to be slow and high inflation to continue to prevail. (See Table 4.) After the 1973-75 recession, employment rebounded rapidly, including employment in the automobile industry. However, many automobile analysts do not foresee this occurring in 1981. Instead, they are predicting that foreign manufactured cars will account for a growing share of the U.S. automotive market, and that many automobile workers who are on indefinite lay-off will not return to the automotive ranks. Many steel workers will also not be rehired when the recession ends. Steel plants in Indiana, Ohio, California, Connecticut, Alabama, Pennsylvania, and New Jersey are scheduled to be permanently shut down. In addition, if fines are imposed on European steel producers for selling steel in U.S. markets below cost, Europe will probably retaliate against the chemical industry (which they claim is getting government subsidies because U.S. energy prices have been kept artificially low).

Such retaliation will have an adverse effect on employment in the chemical industry.

Table 4

PROJECTIONS OF PERCENTAGE CHANGE IN ANNUAL RATES
OF GROWTH OF VARIOUS ECONOMIC INDICATORS

	1978	1979	1980e	1980-84e	1985-89e
Real GNP	4.5*	2.3*	-0.5**	2.5**	3.0**
GNP price deflator	7.3*	8.8*	9.5**	8.6**	7.1**
Unemployment rate (average)	6.0*	5.8*	8.0***	6.7**	5.9**
Hospital Market Basket****	8.7	10.5	11.6	N/A	N/A

Sources:
* United States Government Printing Office, Economic Indicators, April 1980, pp. 3, 12
** Blue Chip Economic Indicators, Vol. 5, No. 5, May 10, 1980, pp. 2, 7.
*** Chicago Tribune, "Long Slow and Steady Decline in Job Scene", Section 2, pg. 1 May 11, 1980.
**** American Hospital Association, Office of Policy Analysis, HOSPITAL PERFORMANCE, Vol. 2, No. 4, April 1980, p. 2.

II. Financial Effects

a. Utilization

The recession is expected to increase Plan utilization. For example, in a recession workers with little or no seniority are generally laid off first. They are usually the younger workers. The remaining work force generally consists of older workers who tend to utilize health care services more than their

younger colleagues. In addition, many workers who expect their health benefits to terminate shortly may tend to utilize those benefits while they are still available, e.g. they "buy" discretionary medical care while they are covered by their employer, rather than wait until later when they might have to pay the bill themselves. Finally, some economists and physicians link unemployment to death and disease. For example, according to studies performed by M. Harvey Brenner of Johns Hopkins, rising unemployment goes hand-in-hand with increases in heart disease, suicides, homicides, cirrhosis of the liver and admissions to prisons and mental hospitals. These increases in utilization will be detrimental to Plans who cannot pass on increased costs to subscribers. However, some Plans with ASO or cost-plus contracts may not be harmed, and may even benefit financially in the short run from utilization increases. Nevertheless, in the long run everyone loses by higher claim costs.

b. Medical care prices.

The recession is not expected to reduce the rate of increase in medical care prices. Economists expect the CPI to decline from its approximately 17 percent annual rate to a 10-12 percent annual rate by year-end. However, the underlying rate of inflation (increases in the cost of factors of production) which has increased from approximately 7-1/2 percent a year and a half ago to about 12 percent, is not expected to moderate. In recent testimony before the Joint Economic Committee, Robert Russell, Director of the Council on Wage and Price Stability, said that the underlying core rate of inflation is probably going to overtake the rate of increase in the CPI during the second half of 1980. The high core rate of inflation suggests that the rate of increase in medical care prices will not decelerate in 1980 and 1981. (See Table 4.)

c. Interest rates

Many economists believe that the recent sharp decline in both short-term and long-term interest rates is the first phase of a rate decline that will persist through the end of the year and into 1981. In addition, they believe that the rate declines in future quarters will not be as dramatic as recent changes, and that temporary increases may occur. However, analysts claim that the underlying trend is down, and by the end of the year, the prime rate may be 10 percent or less; other short-term rates may be 75-100 basis points lower. Thus, net investment income may be less in 1980 than in 1979.

III. Conclusion

A recession primarily hurts Plans indirectly through damage it inflicts on Plan customers. If a Plan has a large proportion of its contracts in the manufacturing sector (other than in industries such as autos where covered benefits for terminated employees continue for substantial periods after employment ends) or construction, it is likely to experience a drop in enrollment and perhaps in subscription income. In addition, recessions may hurt Plans by causing an increase in utilization. While the increase in utilization is detrimental to Plans which operate on an insurer basis and cannot quickly pass increases in utilization on to subscribers, it may be temporarily beneficial to the extent that Plans have ASO or cost-plus contracts. Finally, recessions hurt Plans by reducing investment income rates of return.

RECENT TRENDS IN SURGERY UTILIZATION

Here are findings of surveys of recent surgery utilization trends among Blue Cross and Blue Shield Plan subscribers and the Federal Employee Program (FEP). This study grew out of the Voluntary Effort's National Steering Committee's concern, voiced at its October, 1979 meeting, about the effects of overall surgery utilization growth on total hospital utilization growth; and particularly whether elective surgery was an important factor in these trends. One of the principal findings is surgery utilization for 26 procedures for FEP and Blue Cross and Blue Shield Plan subscribers declined slightly, while the AHA Panel Survey surgery utilization for all surgery increased significantly between the first halves of 1978 and 1979. The other major finding is elective surgery trends are not significantly different from total surgery trends for FEP and Blue Cross and Blue Shield Plan subscribers.

Surgery utilization data have been collected from 44-Plans and the FEP program for 26 procedures for the first halves of 1979 and 1978. These 26 procedures were identified by staff of the Associations' Health Economics Research Department in conjunction with the AMA to be broadly representative of all surgery. For the 44-Plans the data are for all regular business including FEP, but excluding government programs like Medicare and Medicaid. These data are by date of service within the first half of each year with a follow-up date of payment through September of the same year.

All FEP claims were screened for a maximum 18-month follow-up date of payment. For example, a claim incurred in January, 1974 would be followed-up through the end of June, 1975 for date of payment.

Table 5 is a compilation of average changes in cases per contract by procedure from the first half of 1978 to the first half of 1979. The 1971 Blue Shield Plan Procedure Code is used to identify procedures. In the wire survey of Plans, 13 procedures increased in frequency; 13 procedures either declined or had no change. In individual FEP contracts, 4 procedures increased; 22 procedures declined or had no change. In family FEP contracts, 5 procedures increased; 21 procedures declined.

Table 6 is average change in cases per contract by procedure groups. The number in front of each procedure in Table 5 identifies which group each procedure belongs to. They are not definitive groupings, but rather possible classifications of individual procedures into roughly comparable groupings according to the four-part classification. There were three negative changes and one positive change for the four groupings for the 44-Plan data set. For FEP individual and family contracts, all procedure groupings were slightly negative. Groupings of procedures did not show any one group to have changes significantly different from the other groups. Overall average change for the 26 procedures per contract for the wire survey and FEP individual and family contracts was slightly negative. The probability the declines result from chance is not insignificant, suggesting the declines may be random variation in utilization rates and not some fundamental shift in utilization.

Summary

During the same time period surgery utilization, monitored by the AHA Panel Survey, increased 4.7%. Differences in sampling procedures and populations and the impact of cost containment programs of Blue Cross and Blue Shield Plans and the Voluntary Effort can account for differences in the surgery rates of the FEP and Blue Cross and Blue Shield Plan subscribers and the population sampled by the AHA Panel Survey.

TABLE 5: AVERAGE CHANGE IN CASES PER CONTRACT PER PROCEDURE: FIRST HALF OF 1979 COMPARED TO FIRST HALF OF 1978

1971 Blue Shield Procedure Code	Procedure Grouping Number	Procedure	Average Change in Cases Per Contract Across 44 Plans	Average Change in FEP High Option Cases Per Contract	
				Individual	Family
0060	4	Skin Biopsy	.000179	-.000006	.000039
0463	1	Excision of cyst, breast	-.000307	-.000038	-.000191
0473	4	Simple mastectomy, female, unilateral	.000000	-.000010	-.000029
1045	4	Distal radial fracture (e.g., Colles type), closed reduction	-.000043	-.000010	-.000048
1102	4	Open reduction of fracture-neck of femur, internal fixation of prosthetic replacement	.000021	.000046	.000009
1261	1	Meniscectomy, excision of semi-lunar cartilage of knee joint	.000024	-.000034	-.000114
1330	1	Total hip replacement	.000055	.000011	.000017
2180	2	Bronchoscopy, diagnostic	-.000090	-.000096	-.000099
2700	1	Saphenous veins, ligation and division and complete stripping	-.000010	-.000007	-.000052
*3107	1	Tonsillectomy and Adenoidectomy - Juvenile	.000038	.000000	-.000108
*3108	1	Tonsillectomy and Adenoidectomy - Adult	.000008	-.000069	-.000198
3270	4	Collectomy, partial	.000034	-.000047	.000073
3350	4	Appendectomy	-.000045	-.000069	-.000256
3400	2	Sigmoidoscopy, diagnostic	.000026	-.000057	-.000264
3476	1	Hemorrhoidectomy, internal and external	-.000050	-.000103	-.000200
3620	1	Cholecystectomy	-.000065	.000010	-.000125
3746	1	Herniorrhaphy, inguinal, unilateral	.000033	-.000027	-.000067

*One Plan did not report data for this procedure in the wire survey of Plans.
**Three Plans did not report data for this procedure in the wire survey of Plans.

TABLE 5 : AVERAGE CHANGE IN CASES PER CONTRACT PER PROCEDURE:
FIRST HALF OF 1979 COMPARED TO FIRST HALF OF 1978

1971 Blue Shield Procedure Code	Procedure Grouping Number	Procedure	Average Change in Cases Per Contract Across 44 Plans	Average Change in FEP High Option Cases Per Contract	
				Individual	Family
4021	2	Cystourethroscopy (1964 Cystoscopy codes), codes), diagnostic, hospital	-.000032	-.000083	-.000301
4073	1	Prostate, TUR, complete	.000040	-.000030	-.000040
4351	3	Vasectomy	-.000218	-.000016	-.000075
4681	1	D & C, non-obstetrical	.000008	-.000236	-.000458
4685	1	Hysterectomy, total	.000061	-.000034	-.000309
**4740	3	Tubal ligation, abdominal approach	-.000116	-.000033	-.000151
4927	1	Thyroidectomy, subtotal	.000000	-.000027	-.000034
5176	1	Lamiotomy, disc, lumbar	.000017	.000042	.000029
5570	1	Extraction of lens (intracapsular/ extracapsular) with or without iridectomy, unilateral	-.000071	-.000021	-.000021

*One Plan did not report data for this procedure in the wire survey of Plans.
**Three Plans did not report data for this procedure in the wire survey of Plans.

TABLE 6: AVERAGE CHANGE IN CASES PER CONTRACT BY PROCEDURE GROUPS: FIRST HALF OF 1979 COMPARED TO FIRST HALF OF 1978

Procedure Grouping Number	Procedure Group	Average Change in Cases Per Contract By Procedure Group For 44 Plans	FEP HIGH OPTION	
			Average Change in Cases Per Individual Contract By Procedure Group	Average Change in Cases Per Family Contract By Procedure Group
1	Elective	-.000028	-.000038	-.000125
2	Elective Diagnostic	-.000050	-.000079	-.000221
3	Patient Elective	-.000125	-.000025	-.000113
4	Non-elective	.000023	-.000016	-.000036
Overall Average Change per Contract For 26 Procedures		-.000022	-.000042	-.000114
Probability Overall Average Change Per Contract For 26 Procedures Is Due To Chance		N/A*	43.5%	37.3%

*The distribution of overall average change for all the 44 Plans was not normal.

CURRENT MEDICAL CARE PRICE, UTILIZATION AND COST STATISTICS

Consumer Price Index for All Urban Consumers, U.S. city average, unadjusted March 1980 to April 1980. (See tables 7 and 8.)

- The All Items index increased 1.1 percent, in contrast to a 1.4 percent increase in March. The slowdown in the April rate was attributed to smaller price increases for gasoline, food, clothing and home finance charges.
- Medical care prices increased 0.7 percent, or 0.4 percentage point less than the All Items index. However, according to a BLS spokesman, the April rate of increase in medical care prices was depressed due to a retained earnings adjustment in the unpublished insurance component. (There was a decrease in retained earnings of commercial carriers.) Without the adjustment, medical care increased by 0.9 percent.
- Physician services prices increased 1.0 percent. The increase was attributed to higher physician overhead.
- Dental services prices increased 1.3 percent. The increase was primarily attributed to higher overhead costs, particularly the cost of gold.
- Hospital and other medical care services prices increased 0.7 percent, in contrast to 0.8 percent in March 1980, and 0.4 percent in April 1979.
- Hospital room charges increased 0.5 percent, in contrast to 0.6 percent in March 1980 and 0.3 percent in April 1979.

Table 7
Percent Change in the Consumer Price Index
for All Urban Consumers (CPI-U),
U.S. city average

	March 1980 April 1980	April 1979 April 1980
All items	1.1	14.7
Services	1.5	16.9
Food and Beverages	0.7	7.3
Housing	1.3	17.3
Apparel and Upkeep	0.7	7.2
Transportation	1.3	21.6
Energy	1.1	43.4
Medical Care	0.7	11.4
Physician Services	1.0	10.7
Hospital and Other Medical Care Services	1.7	12.6
Hospital Room	0.5	12.6

Source: Bureau of Labor Statistics.

FIGURE I

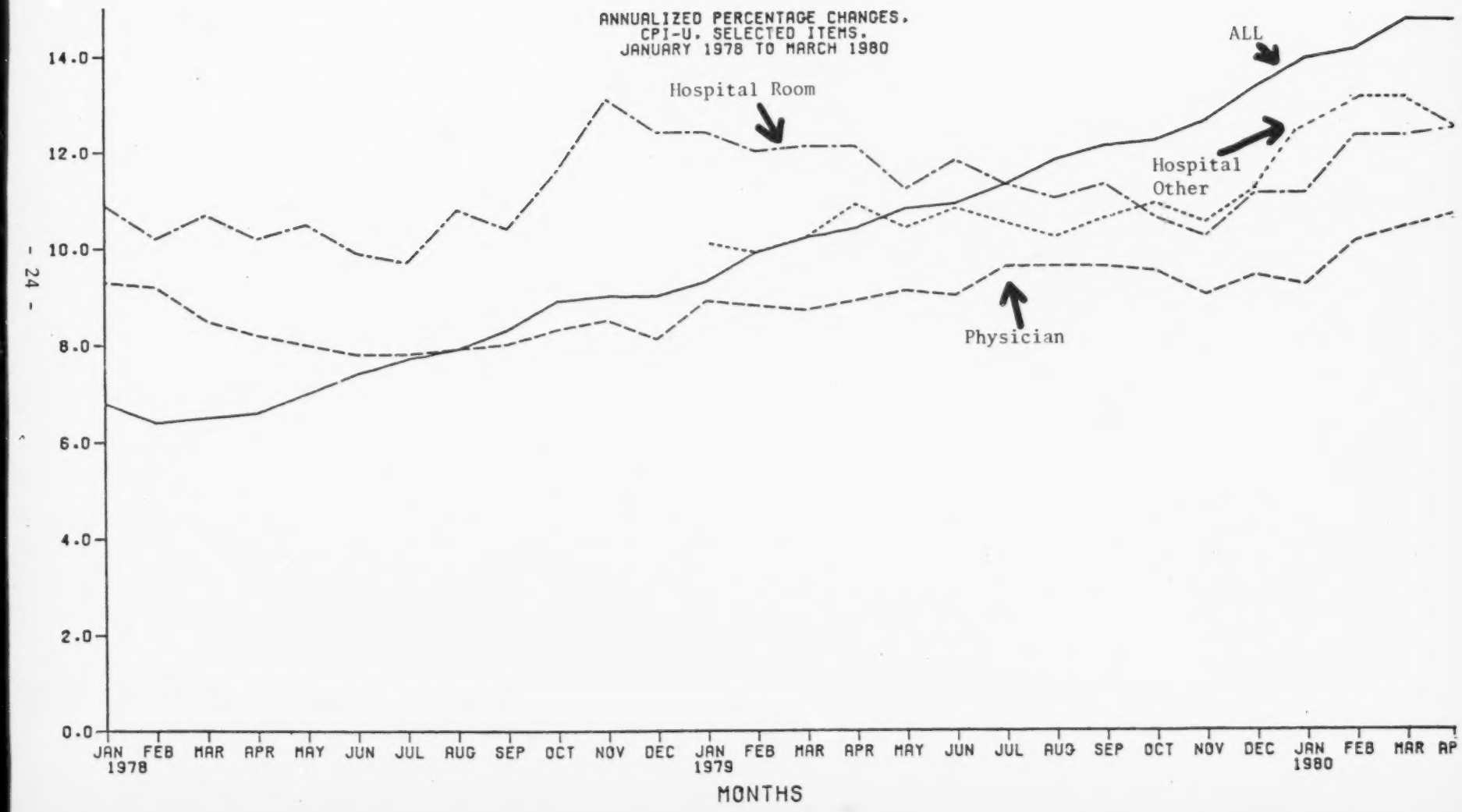
ANNUALIZED PERCENTAGE CHANGES.
CPI-U. SELECTED ITEMS.
JANUARY 1978 TO MARCH 1980
ALL
Hospital Room
Hospital
Other
Physician
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
JAN 1978
FEB
MAR
APR
MAY
JUN
JUL
AUG
SEP
OCT
NOV
DEC
JAN 1979
FEB
MAR
APR
MAY
JUN
JUL
AUG
SEP
OCT
NOV
DEC
JAN 1980
FEB
MAR
AP
MONTHS

Table 8
CONSUMER PRICE INDEX OF ALL URBAN CONSUMERS,
U.S. city average, unadjusted

	January 1980		
	Index 1967=100	Percentage 1 month	Change for 12 months
All Items	233.2	1.4	13.9
Medical Care	253.9	1.3	10.1
Medical Care Commodities	160.5	0.8	7.9
Medical Care Services	274.4	1.4	10.5
Professional Services	238.9	1.3	9.0
Physician Services	256.0	1.4	9.2
Dentist Services	227.4	1.3	9.4
Other Professional Services	116.6	1.3	7.7
Other Medical Care Services	317.4	1.5	11.9
Hospital and Other Medical Care Services	125.6	1.5	12.3
Hospital Room	395.3	1.5	11.1
Other Hospital and Medical Care Services	124.7	1.5	11.5
Services	253.1	1.5	14.5
Services Less Medical Care	249.2	1.6	14.9

	February 1980		
	Index 1967=100	Percentage 1 month	Change for 12 months
All Items	236.4	1.4	14.1
Medical Care	257.9	1.6	10.9
Medical Care Commodities	162.1	1.0	8.0
Medical Care Services	279.0	1.7	11.4
Professional Services	242.9	1.7	10.0
Physician Services	260.2	1.6	10.1
Dentist Services	231.5	1.8	10.6
Other Professional Services	118.1	1.3	8.5
Other Medical Care Services	322.7	1.7	12.7
Hospital and Other Medical Care Services	127.8	1.8	13.1
Hospital Room	403.4	2.0	12.3
Other Hospital and Medical Care Services	126.5	1.4	12.6
Services	256.8	1.5	15.0
Services Less Medical Care	252.7	1.4	15.4

Source: Bureau of Labor Statistics

Table 8 (cont.)
CONSUMER PRICE INDEX OF ALL URBAN CONSUMERS,
U.S. city average, unadjusted

	March 1980		
	Index 1967=100	Percentage 1 month	Change for 12 months
All Items	239.8	1.4	14.7
Medical Care	260.2	0.9	11.2
Medical Care Commodities	163.5	0.9	8.5
Medical Care Services	281.5	0.9	11.8
Professional Services	245.3	1.0	10.6
Physician Services	262.3	0.8	10.4
Dentist Services	234.1	1.1	11.3
Other Professional Services	119.5	1.2	9.7
Other Medical Care Services	325.3	0.8	12.9
Hospital and Other Medical Care Services	128.8	0.8	12.3
Hospital Room	405.8	0.6	12.3
Other Hospital and Medical Care Services	127.8	1.0	12.2
Services	261.3	1.8	16.0
Services Less Medical Care	257.4	1.9	16.6

CONSUMER PRICE INDEX OF ALL URBAN CONSUMERS,
U.S. city average, unadjusted

	April 1980		
	Index 1967=100	Percentage 1 month	Change for 12 month
All Items	242.5	1.1	14.7
Medical Care	262.0	0.7	11.4
Medical Care Commodities	164.9	0.9	8.8
Medical Care Services	283.4	0.7	11.4
Professional Services	248.2	1.2	10.7
Dentist Services	264.8	1.0	12.2
Other Professional Services	121.7	1.3	12.2
Other Medical Care Services	325.8	0.2	11.5
Hospital and Other Medical Care Services	129.7	0.7	12.6
Hospital Room	408.0	0.5	12.6
Other Hospital and Medical Care Services	128.0	0.5	12.5
Services			
Services Less Medical Care			

Source: Figures for January thru March were obtained from Bureau of Labor Statistics, Figure for April were obtained from a telephone conversation with a BLS staff.

Table 9a

Percent Charge in CPI-U, Selected Cities

	Feb. 80 to April 1980		April 1979 to April 1980	
	All Items	Medical Care	All Items	Medical Care
All Cities	2.6	1.6	14.7	11.4
Atlanta	2.2	0.9	13.8	7.3
Buffalo	2.5	1.1	13.1	7.6
Chicago-Northwestern Indiana	3.2	2.8	15.0	15.0
Cleveland	1.6	-0.4	15.0	10.1
Dallas-Forth Worth	4.0	3.8	19.1	10.9
Detroit	3.2	1.4	16.4	8.7
Honolulu	2.9	4.0	13.3	8.6
Houston	1.9	1.9	14.3	11.1
Kansas City	2.1	1.7	15.3	11.3
Los Angeles-Long Beach-Anaheim	2.9	3.1	17.7	15.7
Minneapolis-St. Paul	2.7	0.3	13.2	13.9
New York-Northeastern New Jersey	2.2	2.0	11.9	10.4
Philadelphia	2.7	0.4	14.3	10.9
Pittsburgh	2.3	1.7	13.6	10.7
San Francisco-Oakland	1.2	2.2	16.6	13.0

Source: Bureau of Labor Statistics. Figures obtained from a telephone conversation with a member of the BLS staff.

Table 9b

Percentage Change in the CPI-U,
U.S. city average and selected areas

	Jan. 1980 to Mar. 1980		Mar. 1979 to Mar. 1980	
	All Items	Medical Care	All Items	Medical Care
U.S. city average	2.8	2.5	14.7	11.2
Anchorage, Al.	2.4	5.4	11.1	14.4
Baltimore, Md.	4.5	1.9	12.0	10.2
Boston, Ma.	3.0	0.9	14.2	10.6
Chicago, Il. - N.W. Ind.	1.9	3.3	14.9	12.9
Cincinnati, Oh. - Ky. - In.	3.5	2.5	14.9	9.0
Denver - Boulder, Co.	3.2	1.0	14.4	12.8
Detroit, Mi.	3.1	0.3	15.1	8.6
Los Angeles, - Long Beach - Anaheim, Ca.	4.2	3.9	17.2	12.9
Miami, Fl.	3.6	1.2	14.8	12.0
Milwaukee, Wi.	2.7	2.5	16.9	12.3
New York - Northeastern N.J.	2.3	2.7	11.1	9.3
Northeast, Pa. (Scranton)	2.0	0.8	12.5	9.5
Philadelphia, Pa.	3.3	3.5	13.2	10.8
Portland, Or.	3.7	3.5	17.7	14.1
St. Louis, Mo.	2.3	0.7	14.3	13.8
San Diego, Ca.	1.7	1.6	16.7	9.1
Seattle - Everett, Wa.	3.3	1.7	17.8	17.8
Washington, D.C. - Md. - Va.	3.0	1.5	12.3	8.4

Source: Bureau of Labor Statistics. Figures obtained from a telephone conversation with a member of the BLS staff.

AHA Panel Survey (See Table 10).

Total hospital expenses for January and February were 14.4 percent and 18.4 percent greater than in the same month one year earlier. However, February 1980 had one day more than February 1979. When adjusted for leap year, total expenses increased 14.5 percent in February 1980.

-Inpatient hospital expenses for January 1980, February 1980, and February 1980 adjusted for leap year were 13.7 percent, 18.0 percent, and 14.2 percent greater than in the corresponding month one year earlier. In January 1980 and February 1980, the cost of treatment of an average case was 10.7 percent and 9.6 percent greater than in the corresponding month one year earlier. In January 1980 the average cost of a hospital stay was $1,632 and the average cost of a day of care was $231.

-Inpatient hospital utilization increased in the first two months of 1980 primarily because of the sharp increase in admissions of persons age 65 and over. The increase was primarily attributed to the influenza epidemic, which was more severe than in 1979. Many older people were admitted and treated in hospitals because there was no one at home to care for them.

-Outpatient visits increased sharply in the first 2 months of 1980, reversing the 1979 trend. (See table 11.)

-The Hospital Market Basket continued to increase at a rapid rate in the first two months of 1980 as a result of higher wage, energy, interest, and non-medical supply costs.

-February was the first month in five years in which the hospital occupancy rate was over 80 percent. Absolute reductions in bed capacity occurred in the mid-Atlantic and West North Central regions, while the largest increase in capacity occurred in the Mountain region.

Table 10

PERCENTAGE CHANGE IN SELECTED HOSPITAL EXPENSES,
UTILIZATION AND COSTS

	Change from same month one year earlier					Calendar Year	
	Jan. 1979	Jan. 1980	Feb. 1979	Feb. 1980	Feb. 1980 Adj	1978	1979
Total Expenses	14.4	14.4	12.7	18.4	14.5	12.8	13.4
Inpatient Expenses	13.9	13.7	12.1	18.0	14.2	12.3	13.3
Inpatient Expenses/ Admissions	9.2	10.7	9.8	9.6	9.9	11.8	12.4
Inpatient Admission	4.3	2.7	2.2	7.6	3.9	0.4	2.7
Average length of stay	-3.6	-0.4	-1.6	0.1	0.1	-0.3	-1.0
Over 65 Admissions	1.8	7.9	4.4	13.6	9.7	4.9	5.3
ALOS 65+	-2.6	-1.2	-2.0	-1.0	-1.0	-1.2	-1.9
Under 65 Admissions	5.2	0.9	1.4	5.5	1.8	-1.0	1.7
ALOS 0-64	-3.6	-1.3	-1.9	-0.7	-0.7	-0.9	-1.2
Birth	7.1	0.1	3.4	8.0	4.3	0.6	4.4
Surgeries	10.4	4.6	5.2	10.4	6.6	1.0	3.9
Beds	1.2	0.4	1.0	0.4	0.4	0.9	0.6
Census	0.5	2.2	0.5	4.0	4.0	0.1	1.6
Percent Occupancy	77.2	78.6	77.5	80.2	80.2	73.7	74.5
Outpatient visits	2.2	6.8	-4.1	14.0	10.1	0.4	-0.3
Hospital Market Basket	9.5	11.9	9.4	12.6	12.6	8.7	10.5

Source: American Hospital Association, Office of Policy Studies, TRENDS, No. 28, April 1980 and No. 29, May 1980.

Hospital Utilization (See Table 11).

Community hospital admissions rose 2.7 percent in 1979 as a result of (1) continued growth and aging of the population, and (2) increased admissions rates. The former increased 1.2 percent in 1979, and accounted for 44 percent of the increase, while the later increased 1.5 percent, and accounted for 56 percent of the increase.

Table 11

PERCENTAGE CHANGE IN HOSPITAL UTILIZATION

	Percent Change from Previous Year		
	1977	1978	1979
Admissions	2.5%	0.4%	2.7%
65 and over	4.4	4.9	5.3
Under 65	1.9	-1.0	1.7
Average Length of Stay	-1.7	-0.3	-1.0
65 and over	-3.0	-1.2	-1.9
Under 65	-1.4	-0.9	-1.2
Outpatient Visits	6.0	0.4	-0.3
Clinic Visits	7.5	-4.5	-4.2
Emergency Room Visits	4.2	1.7	0.6
Referred and Other	6.8	2.1	1.0

Source: American Hospital Association, Office of Policy Analysis, HOSPITAL PERFORMANCE, Vol. 2, No. 4 April 1980, p. 8.

AHA Hospital Cost (HCI) and Hospital Intensity (HII) Indexes (See Table 12.)

The Hospital Cost Index (HCI) reflects changes in the price of a hospital market basket consisting of 46 procedures, the hospital intensity index (HII), reflects changes in the quantity of these same procedures, and the real service volume index (RSV) adjusts the intensity index (HII) for changes in seasonally adjusted patient days.

Table 12

Percentage Change in Hospital Cost and Intensity Index

	12 Month Period Ending		
	December 1979	January 1980	February 1980
Hospital Cost Index (HCI)	10.32 r	10.85	10.52 p
Hospital Intensity Index (HII)	0.74 r	1.46	0.33 p
Real Service Volume (RSV)	1.02 r	4.36	8.40 p

r. revised

p. preliminary

Source: American Hospital Association

FIGURE II

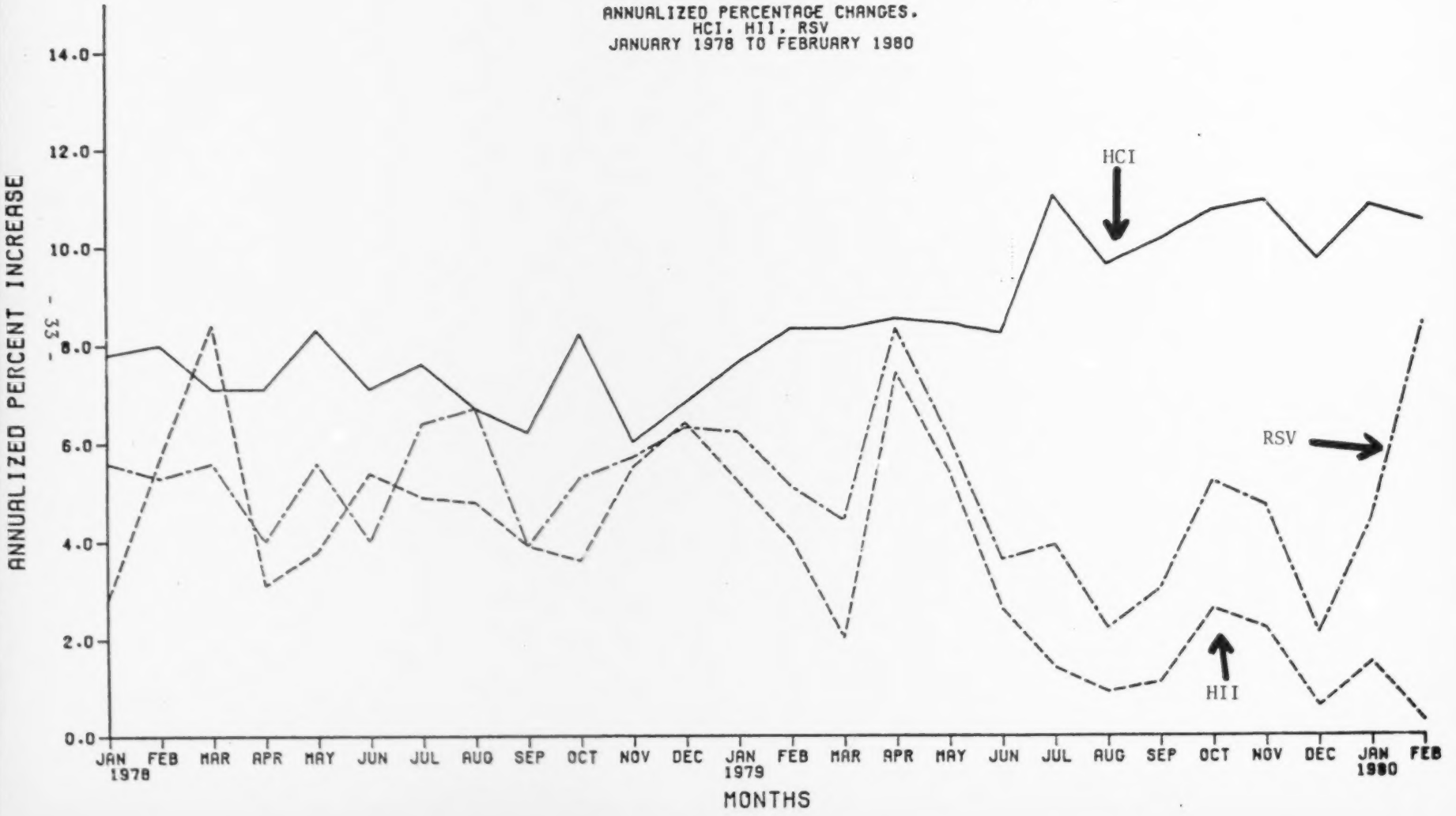
ANNUALIZED PERCENTAGE CHANGES.
HCI. HII. RSV
JANUARY 1978 TO FEBRUARY 1980
ANNUALIZED PERCENT INCREASE
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
HCI
RSV
HII
JAN 1978
FEB
MAR
APR
MAY
JUN
JUL
AUG
SEP
OCT
NOV
DEC
JAN 1979
FEB
MAR
APR
MAY
JUN
JUL
AUG
SEP
OCT
NOV
DEC
JAN 1980
FEB
MONTHS

TABLE 13

Unemployment Rates for the 10 Largest States seasonally adjusted

	Dec. 1979	Jan. 1980	Feb. 1980	March 1980	April 1980
California	6.2	5.8	6.1	6.0	7.1
Florida	5.4	5.1	5.2	5.2	5.5
Illinois	6.4	7.1	7.0	6.9	7.4
Massachusetts	5.6	5.0	4.8	4.9	5.3
Michigan	8.7	9.5	10.3	10.2	12.2
New Jersey	6.5	6.9	5.4	6.9	6.6
New York	7.3	7.7	7.6	6.9	7.2
Ohio	5.8	6.3	6.1	5.9	7.4
Pennsylvania	7.1	7.2	6.8	6.8	7.7
Texas	3.9	4.8	4.9	5.8	5.4

Source: Bureau of Labor Statistics

TABLE 14

EMPLOYEE COMPENSATION PRIVATE NONFARM ECONOMY
Selected Year, 1970-77
(Percent of Compensation)

	1970		1972		1974		1976		1977	
	All Industry	Mfg.	All Industry	Mfg.	All Industry	Mfg.	All Industry	Mfg.	All Industry	Mfg.
Total Compensation	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Wages and Salaries*	89.0	88.0	87.8	86.5	86.3	84.9	84.7	83.4	84.5	82.7
Supplements to Wages and Salaries**	11.0	12.0	12.2	13.5	13.7	15.1	15.3	16.6	15.5	17.3
Employee Expenditure for Life Insurance and Health Benefits	4.2	5.0	4.7	5.4	4.9	5.9	6.0	6.9	6.0	7.1
Life, Accident and Health	2.6	3.6	3.0	4.0	3.3	4.3	4.1	5.0	4.0	5.2

* Wages and salaries include all direct payments to workers. They consist of pay for time worked, pay for vacations, holidays, sick leave, and civic and personal leave, severance pay; and nonproduction bonuses.

** Supplements to wages and salaries include all employer expenditures for compensation other than wages and salaries. They consist of expenditures for retirement programs (including direct pay to pensioners under pay-as-you-go private pension plans); expenditures for life insurance and health benefit programs (except sick leave); expenditures for unemployment benefit programs (except severance pay); payment to vacation and holiday funds; and payments to savings and thrift plans.

Source: Department of Labor, Bureau of Labor Statistics, "Employee Compensation in the Private Nonfarm Economy", Selected years, 1966-74, 1976, and 1977.

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June/July

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EXECUTIVE SUMMARY

THE RE-INDUSTRIALIZATION OF AMERICA AND ITS IMPACT ON PLANS

The "reindustrialization of America" which many people are talking about, is likely to have a positive impact on Plan enrollment. However, it could slow the expansion of new benefits as a result of economic incentives to increase capital formation and to restrain public and private consumption. It is also likely to put more pressure on Plans to increase the cost effectiveness of claims processing, to offer a wide range of coverage, and to seek to restrain the rate of increase of hospital cost and physician fees.

A COMPARISON OF THE IMPACT OF THE 1973-75 RECESSION AND THE 1980 RECESSION ON PLAN ACTIVITIES

The 1973-75 recession was the worst since the Great Depression. The 1980 recession, which began in January, is not expected to be as bad as the 1973-75 recession. However, it is likely to have a more severe impact on Plan performance.

Plans began the 1980 recession in a relatively weaker state than the 1973-75 recession. The 1980 recession is likely to affect Plan enrollment and financial health. For example, in contrast to the earlier recession, the 1980 recession is expected to result in high employment for a prolonged period and to cause permanent reductions in employment in several manufacturing industries, some of which are major Plan accounts, e.g., auto, steel, and rubber.

Trends (price and utilization) are likely to continue to increase but the COWPS price standard restrains trends which can be used to set premiums. In 1979, increases in net investment income were able to offset underwriting losses. However declining interest rates, due to the recession, are likely to prevent this from recurring. Thus the 1980 recession is likely to make it more difficult for Plans to increase market penetration, reduce utilization, and prevent underwriting losses and reductions in reverse.

On the otherhand, the 1980 recession is not expected to significantly reduce the rate of increase in medical care prices. It is not likely to reduce the rate of increase in the number of new physicians or the cost of dying, factors contributing to rising costs. Thus, the 1980 recession is not likely to reduce the pressures on Plans from government, business, and labor to provide alternative financial managements and offer direct pay contracts.

THE RE-INDUSTRIALIZATION OF AMERICA AND ITS IMPACT ON PLANS

Introduction

Business leaders, economists and presidential candidates are attributing the nation's declining productivity, slow economic growth, inflationary pressures and inability to compete successfully in international trade (particularly in manufacturing) to decades of over-consumption and under-investment in economic resources. They are calling on government to embark upon a program to shore up the nation's productive capacity to reverse this situation. The program is called "the re-industrialization of America."

Most advocates of re-industrialization want government to provide economic incentives to increase capital formation. Incentives would include accelerated depreciation, additional stimulus for research and development and tax incentives for savings and investment. Other advocates of re-industrialization suggest that some industries, e.g., autos and steel, be selected as "winners," and that these industries receive government help. For example, Felix Rohatyn and Henry Kaufman have suggested establishing a $5 billion revolving fund (or a renewed Reconstruction Finance Corporation) to help the winners overcome their obsolescence and to become more competitive. At the same time, other industries would be targeted as "losers," and allowed to die.

Some economists, e.g., Gar Alperovitz and Jeff Faux, suggest that various types of national planning be used to re-industrialize the nation.

Most advocates of re-industrialization recognize that a trade-off will have to be made, i.e., that the nation cannot continue to consume at its present rate and embark upon a program to shore up its capital goods industries. Thus, public and private consumption sacrifices will be required if the nation is to continue to be able to provide its citizens with a high standard of living, social benefits and security. Among the sacrifices often mentioned is a slowdown in the rate of growth of employee compensation.

Impact on Plans

Re-industrialization is likely to benefit Plan enrollment because it will increase production (and therefore employment) in the manufacturing sector, particularly durable goods, where Plans have a high market penetration. Moreover, many economists are predicting that unless government provides economic incentives for the auto and steel industries, employment in those industries which rely on the automobile and steel industries for a substantial part of their supply and demand is likely to decline. Since several industries where declines in employment are likely to occur are also major Plan accounts, Plan enrollment probably would benefit from economic incentives.

However, re-industrialization could slow the expansion of benefits. Successful re-industrialization requires government, business and consumers to tighten their belts and restrain their appetites for public and private consumer goods, including health benefits. A change in the tax treatment of savings and investments to increase capital formation could reduce the demand for health benefits. For example, if deductions were allowed for amounts added to savings accounts or the effective tax rate on investment income were

lowered, employees might prefer to receive a larger portion of their total compensation in the form of cash rather than fringe benefits such as health insurance.

If the rate of increase of employee compensation slows, it is likely that the reduction will be reflected in both cash and fringes, such as health benefits. Moreover, if medical care costs continue to increase at current rates (while the growth of cash wages slows), Plans might be under even more severe pressure to restrain the rate of increase of their premiums (by reducing benefits and/or limiting utilization). Unless they are able to restrain premium increases, Plans may lose a portion of their business to union or employer-administered health plans, who believe they can operate more efficiently. Another danger which a relative decline in employee compensation poses to Plans who cannot restrain costs is that political pressures may cause government bodies who have (or may acquire) authority over rate increases to force Plans to absorb a portion of the higher costs by delaying or denying requests to pass on higher medical costs in the form of higher premiums.

Possibility of a Re-Industrialization Program

The 1980 election and recession are likely to result in the implementation of some parts of a re-industrialization program. President Carter has already announced certain measures to aid the automobile industry. Transportation Secretary Neil Goldschmidt has indicated that additional and more significant measures to aid the auto industry are being considered by the administration. In addition, steel industry executives hope that trigger prices will be raised late this year and that accelerated depreciation schedules will become effective in 1981. Finally, political and economic

analysts believe that an election year tax cut for business and individuals is all but certain.

It is too early to tell what method will be used to reduce business taxes -- accelerated depreciation, investment tax credits or reducing the corporate income tax rate. Each method benefits different types of businesses. Whatever method is used, it will be intended to increase employment as well as capital formation.

The tax cut is likely to have a positive impact on Plans in that it will stimulate employment. Thus, it is likely to result in an increase in enrollment in some accounts, while reducing the decline in employment in other accounts, e.g., steel, auto, rubber, etc. Individual taxes will also be reduced, but most economists do not believe the reduction in individual tax rates will be meaningful in that the reduction will only partially offset the additional taxes people would have had to pay as a result of higher wages, "bracket creep" and other tax increases, e.g., social security.

Impact of Tax Cut on Inflation

At present, most economists, businessmen and politicians do not think a tax cut will re-fuel inflation. They have faith that (1) the Federal Reserve, under the leadership of Paul Volcker, and (2) excess capacity in industry will prevent an acceleration of inflation.

However, the recession and the tax cut are likely to result in a FY 1981 budget deficit of approximately $50 billion. Consequently, government pressures to restrain rising health care costs through further economic controls are likely to occur.

Conclusion

The "re-industrialization of America" which many people are talking about is likely to have a positive impact on Plan enrollment. However, it could slow the expansion of new benefits as a result of economic incentives to increase capital formation and to restrain public and private consumption. It is also likely to put more pressure on Plans to increase the cost effectiveness of claims processing, to offer a wider range of coverage and seek to restrain the rate of increase of hospital costs and physician fees.

A COMPARISON OF THE IMPACT OF THE 1973-75 RECESSION AND THE CURRENT RECESSION ON PLAN ACTIVITIES

Introduction

The National Bureau of Economic Research, the organization responsible for dating U.S. business cycles, has recently announced that economic activity peaked in January, 1980. This marks the beginning of the current recession and is the reference date in a new business cycle. Since a new stage of the business cycle is in progress, it is appropriate to compare the current recession, and its impact on Plans, with the recession of 1973-75.

Comparison of the Impact of the 1973-75 Recession and the 1980 Recession on Plans

The 1973-75 recession was the most severe recession since the Great Depression. However, it had little impact on the growth of Plan enrollment or decline in Plan hospital utilization. Nevertheless, Plans experienced financial losses when mandatory medical price controls were removed four months after the recession began, and rate increases were unable to keep pace with price increases.

The 1980 recession is expected to be the second most severe recession since the 1930s. However, it is likely to have a greater impact on Plan performance.

There are supposed to be some beneficial aspects to a recession. For example, recessions generally reduce inflation. However, the 1980 recession, in contrast to the 1973-75 recession, is not expected to moderate appreciably

the rate of increase in medical care prices. It is also not likely to have an impact on the rapid increase in the supply of physicians or the cost of dying, which have contributed to higher medical care costs in recent years. Pressure on Plans from government, business and labor to contain costs, provide alternative financial arrangements, and offer direct pay contracts is not likely to ameliorate as a result of the 1980 recession.

Recessions have many negative effects. For example, they reduce production and increase unemployment. Many companies cover terminated employees for 3 to 12 months. Moreover, most contracts contain conversion privileges. If companies do not refill positions when business improves or terminated employees do not convert, Plan enrollment is likely to decline.

The 1980 recession, in contrast to the earlier and more severe recession, is expected to result in prolonged high unemployment. In addition, employment in several manufacturing industries, including some which are major Plan accounts, e.g. auto, steel, and rubber, are expected to experience permanent reductions in employment. Predictions of permanent reductions in employment in several major accounts are based on the decline in competitiveness of U.S. manufacturers and the increase in production of small, fuel efficient cars, which require fewer workers and less rubber, steel, glass, electronics, plastics, etc.

Blue Cross hospital utilization did not increase during the 1973-75 recession, in contrast to the general belief that recessions increase utilization. However, there is some indication that Plan utilization may be bottoming out. For example, in calendar year 1979 and the first quarter of

1980, admissions per 1000 regular members were each the same as in corresponding periods one year earlier, while inpatient days per 1000 members and average length of stay per 1000 members each declined from corresponding periods one year earlier.

Some economic demographers are predicting that rising female unemployment is likely to cause birth rates to increase. Recent studies have shown that high inflation and the Age Discrimination in Employment Act is causing the age of the workforce to increase (by reducing the number of early retirement and increasing the number of people working beyond age 65). In addition, in contrast to earlier recessions, employment in some cyclically sensitive industries is not expected to regain pre-slump levels. Thus, some auto, steel and rubber workers who fear they will not be recalled, may increase their utilization before benefits expire.

However, the large number of multiworker families, many of which have overlapping health coverage, may prevent Plan utilization from increasing. In addition, the 1980 recession is not expected to have as severe an impact on certain regions, including regions where Plans have large market penetration, as the earlier recession. For example, New England is not likely to be as severely affected by the current recession as it was in the last recession because of the relative unimportance of steel, autos, rubber and construction in the region's economy and the relative prominence of defense goods and information processing industries. The Southeast is also likely to be less severely affected by the 1973-75 recession because it doesn't have the same excesses in construction and in textiles. While the Midwest is likely to be severely impacted by the current recession, the region's most cyclically

sensitive industries (steel and autos) are becoming less important to the area's structure.

Trends (price and utilization) were accelerating at the beginning of the 1980 recession, in contrast to their performance at the beginning of the 1973-75 recession. Trends are likely to continue to increase but the price standard promulgated by COWPS limits increases in trends that can be used to set premiums. Thus, some Plans have been (and are likely to continue) experiencing underwriting losses.

In 1979, increases in investment income offset underwriting losses. However, the decline in interest rates, a by-product of the recession, may prevent this from recurring. Unless COWPS' 1980 price standard is changed, trends are reversed, and/or insurance commissioners approve higher rates, Plans may experience financial losses. Thus, the 1980 recession is likely to make it more difficult for Plans to increase market penetration, reduce utilization and prevent erosion in their financial well-being.

Economic Environment, 1981-85

The economy is expected to be in the expansion phase of the current business cycle between 1981 and 1985. During that time, many of the factors currently affecting Plan activities -- inflation and competition -- are not likely to change. For example, government (federal and state) pressures to reduce the rate of increase in health care costs are likely to continue. Many political analysts believe the country is moving politically to the right, and that Congress is likely to become more conservative. Although the method Congress uses to restrain health care spending may change -- it may choose to

rely increasingly on tax incentives rather than direct regulation to bring about structural changes in the health care sector -- its objective is not likely to change.

In addition, business is likely to continue to adjust to inflation by seeking to increase the productivity of its capital. Thus, it will probably continue to be interested in alternative financial arrangements, including ASOs and self-insurance, and to continue to focus on the administrative portion of premiums until such time as benefit managers can be convinced that Plan cost containment reduces utilization.

Labor will probably also continue to seek ways to reduce the rate of increase in benefit costs. A few large unions may begin to self-insure if wage increases fall further behind increases in the cost of existing health care benefits. (In 1981, wages are forecast to increase at an approximately 9 percent annual rate, while the cost of existing health benefits is projected to increase at a substantially higher annual rate.)

Government revenues are likely to increase rapidly in the early 1980s as a result of tax changes, "bracket creep" and an expanding economy. Thus, there is likely to be room in the budget for tax reductions or new social programs. This could cause a conflict between business, which is likely to favor additional tax cuts, and labor, which may prefer a comprehensive National Health Insurance Plan.

Competition is likely to continue as (1) commercial insurers and other "for profit" organizations seek a larger share of the health care benefit market, and (2) there is increasing competition among other types of fringes for a larger share of the fringe dollar. Meanwhile, the recession is expected to moderate the rate of increase in employee compensation (cash and fringes).

Blue Cross and Blue Shield Plans may find themselves increasingly competing with "for profit" hospital management companies. The market share of "for profit" hospital management companies has been increasing rapidly in recent years. Wall Street seems to believe that the trend will continue. Some of these companies have recently purchased HMOs. Thus, an increasing number of the firms may shortly become competitors of Plan HMOs and other types of alternative delivery systems.

The recession is not expected to reverse the upward trend in working women and multi-worker families, although the rate of increase in their numbers is expected to slow. A few companies have already begun to offer their employees options among fringe benefits (and not just options among health benefit plans) in an effort to achieve improved employee morale at minimum cost. That trend could increase. Many families currently have overlapping health coverage. An increase in the number of large companies which offer employee choice among fringes could affect Plan enrollment as well as premiums. Carriers which offer flexible benefit structures are likely to obtain a relative benefit from this development.

Conclusion

The 1973-75 recession did not appear to have a significant impact on Plan performance, measured by enrollment or utilization trends. The deteriorating financial health of Plans was related to the inability to obtain rate increases to match increases in medical care prices following the removal of price controls in 1974.

On the other hand, the 1980 recession may have a more serious impact on Plan performance. Plans did not start the recession with favorable enrollment trends and medical care prices were increasing at an accelerating rate. Thus, the recession may make it more difficult for Plans to meet their short-term goals.

The economic environment over the entire span of the latest business cycle (1980-85) will probably continue to be characterized by inflation and competition. Many of the forces currently affecting Plan performance and influencing its behavior are unlikely to change significantly. For example, Plans will continue to experience severe pressures from government, business and labor to contain costs and to offer new and flexible benefit structures. Moreover, competition is likely to continue as competitors seek a larger share of the health care benefit market, and there is increasing competition among other types of fringes for a larger share of the fringe dollar (which is not likely to grow as rapidly as in previous years).

CURRENT MEDICAL CARE PRICE, UTILIZATION

AND COST STATISTICS

Consumer Price Index for All Urban Consumers, U.S. City Average - See Table 1

The one month change in the June CPI-U, seasonally adjusted, was 1.0 percent, in contrast to 0.9 percent in April and May, and 1.4 percent in January, February, and March. The June gain was primarily attributed to rising housing costs.

Many economists had anticipated that the June CPI would increase by less than 1 percent because of the sharp drop in mortgage rates since April. However, June housing costs increased 1.8 percent, in contrast to 1.5 percent in May. The purchase price of homes also increased, despite substantial inventories.

After reviewing the June CPI, several economists said that they no longer expect the CPI to increase at a single digit rate by year-end and that they are in the process of revising their 1980 forecasts. Some of the factors contributing to the revisions are expectations of a shorter recession (ending by year-end), higher food prices caused by the recent drought in the Southwest and parts of the Midwest and higher home prices. (See Table 2 for 1980 and 1981 forecasts of economic indicators.)

However, the CPI is not the only measure of inflation. Other, and perhaps better, measures of changes in prices of goods and services which affect medical care costs are the GNP price deflator, the underlying rate of inflation, the personal consumption expenditures deflator (the price index

used to convert consumption in current dollars to constant dollars) and the producer price index. Most of these indicators are increasing at a 9-10 percent annual rate, i.e., slower than the CPI. Economists are predicting that these other measures of inflation (with the exception of the producer price index) will not change appreciably over the next 12-18 months.

TABLE 1

JUNE CONSUMER PRICE INDEX (CPI-U): U.S. City Average

GROUP	Unadjusted Percentage Change 12 Months	Unadjusted Percentage Change 1 Month	Seasonally Adjusted Percentage Change From 1 Month Ago
All Items	14.3	1.1	1.0
Food and Beverages	7.2	0.7	0.5
Housing	18.3	1.9	1.8
Apparel and Upkeep	6.9	-0.2	0.0
Transportation	17.5	0.3	-0.2
Medical Care	11.4	0.5	0.5
Entertainment	9.1	0.6	0.6
Energy	33.6	1.3	0.3

Source: Bureau of Labor Statistics.

TABLE 2

SOME ECONOMIC PROJECTIONS FOR 1980 AND 1981

	Percent Change (1980 over 1979)			4th Qtr.
	Real GNP	GNP Deflator	Consumer Prices	Percent Unemployment
Evans Economics	-1.3	9.2	13.3	8.9
Chase Econometric Assoc, Inc.	-1.5	8.9	13.7	8.7
UCLA	-1.5	9.3	13.3	9.0
Merrill Lynch	-1.6	8.6	N/A	9.2
Wharton Econometric Forecast	-1.6	9.2	13.5	8.5
Data Resources, Inc.[1]	-1.7	8.9	N/A	8.8
Blue Chip Consensus	-1.4%	9.2%	13.4%	8.8%

	Percent Change (1981 over 1980)			4th Atr.
	Real GNP	GNP Deflator	Consumer Prices	Percent Unemployment
Evans Economics	2.0	9.2	10.6	7.9
Data Resources Inc.[1]	0.8	8.7	N/A	8.4
UCLA	0.7	9.9	9.3	8.3
Merrill Lynch	0.5	7.2	N/A	9.0
Chase Econometric Assoc. Inc.	0.3	9.0	10.3	8.5
Wharton Econometric Forecast	0.3	9.3	9.9	8.1

[1] These data were made available through the courtesy of the CONFERENCE BOARD.

Source: BLUE CHIP ECONOMIC INDICATORS, Vol. 5, No. 7, July 10, 1980, Pg. 3.
For additional information, call Bob Eggert,(606) 282-4882.

Consumer Price Index for All Urban Consumers for Medical Care - See Tables 3-6

Generally, the one month change in medical care prices in the June CPI is relatively small. June 1980 was no exception. The indexes for medical care, medical care services, and other medical care services revealed a continuation of the relatively low monthly rates of change reported in May. According to a BLS staff member, a negative retained earnings adjustment for commercial carriers helped to keep the June figures low. For example, without the adjustment for Blue Cross-Blue Shield Plans and commercial carriers, the monthly rate of change in the CPI-U indexes for medical care, medical care services, and other medical care services would have been 0.7 percent, 0.6 percent, and 0.7 percent, respectively, rather than 0.5 percent, 0.4 percent, and 0.3 percent, respectively.

The VE has been credited for contributing to a moderation in the rate of increase in physician services. The one month and twelve month changes in physician services was 0.6 percent and 11.3 percent, respectively, in contrast to the one month and twelve month changes in services less medical care of 2.0 percent and 18.9 percent, respectively. See Table 3.

Some sharp increases were noted in prices for hospital room and ancillary services according to a BLS spokesman. However, a large proportion of hospitals are on a June 30th fiscal year. Generally, these hospitals' rate adjustments become effective in July and are reflected in the July and August CPIs. Hospital operating expenses and nurses' salaries continued to rise.

The BLS spokesman also indicated that the use of Diagnostic Related Groups (DRG) had a slightly depressing effect on the medical care index for New York-Northeastern New Jersey. However, this effect was reflected more in the CPI-W than in the CPI-U.

FIGURE 1

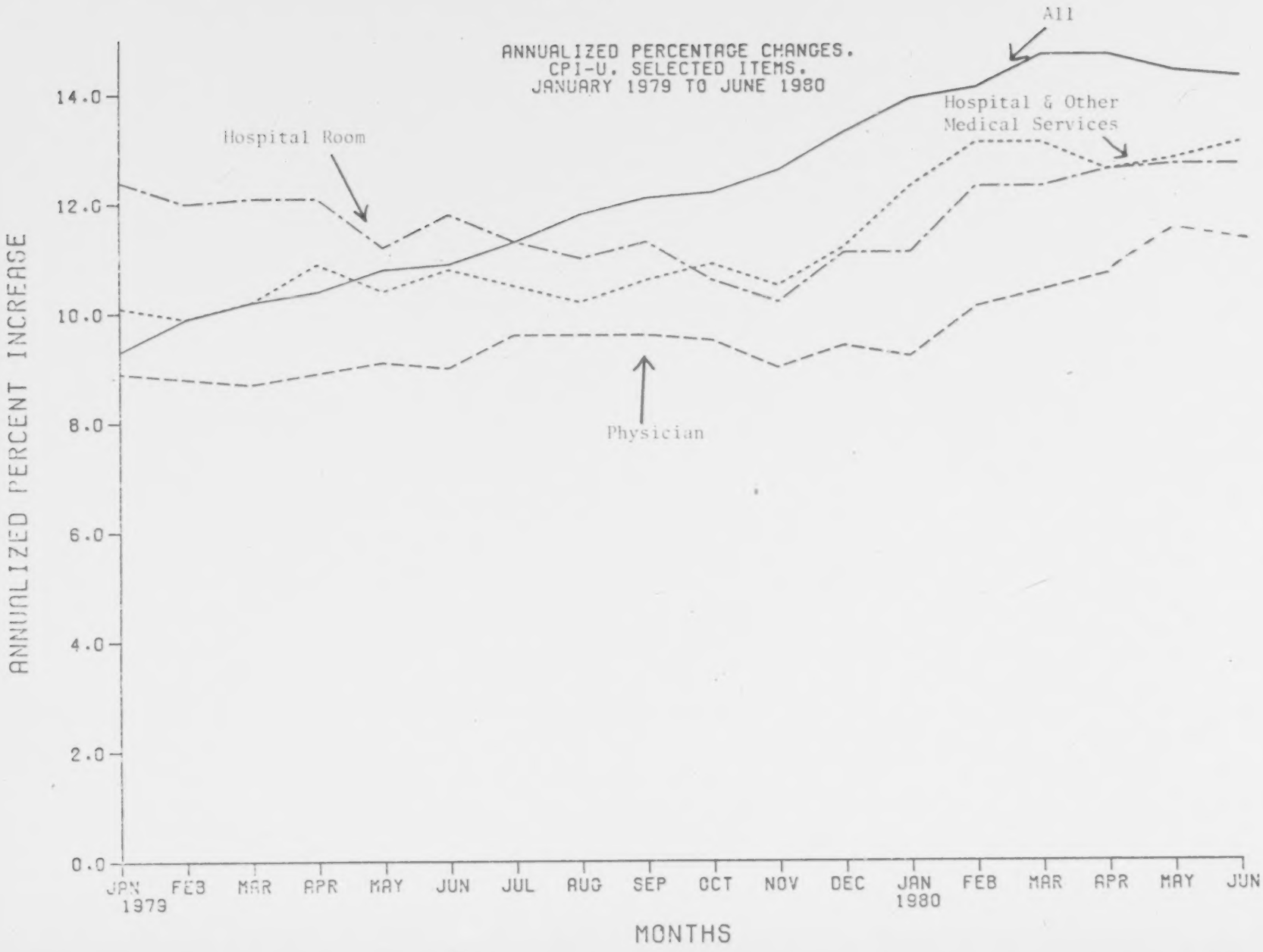

ANNUALIZED PERCENTAGE CHANGES.
CPI-U. SELECTED ITEMS.
JANUARY 1979 TO JUNE 1980
All
Hospital & Other
Medical Services
Hospital Room
Physician
ANNUALIZED PERCENT INCREASE
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
JAN
1979
FEB
MAR
APR
MAY
JUN
JUL
AUG
SEP
OCT
NOV
DEC
JAN
1980
FEB
MAR
APR
MAY
JUN
MONTHS

Table 3

CONSUMER PRICE INDEX OF ALL URBAN CONSUMERS

U.S. CITY AVERAGE, UNADJUSTED

	MAY 1980		
	INDEX 1967 = 100	PERCENTAGE CHANGE FOR 1 MONTH	12 MONTHS
All Items	224.9	1.0	14.4
Medical Care	263.4	0.5	11.5
Medical Care Commodities	166.4	0.9	9.2
Medical Care Services	284.7	0.5	11.9
Professional Services	250.3	0.8	11.6
Physician Services	257.5	1.0	11.1
Dentist Services	268.8	0.7	12.4
Other Professional Services	122.2	0.4	10.9
Other Medical Care Services	326.3	0.2	12.2
Hospital and Other Medical Care Services	130.4	0.5	12.8
Hospital Room	410.1	0.5	12.7
Other Hospital and Medical Care Services	129.5	0.5	12.9
Services	269.2	1.5	17.3
Services Less Medical Care	265.7	1.6	17.9

	JUNE 1980		
	INDEX 1967 = 100	PERCENTAGE CHANGE FOR 1 MONTH	12 MONTHS
All Items	247.6	1.1	14.3
Medical Care	264.7	0.5	11.4
Medical Care Commodities	167.9	9.5	0.9
Medical Care Services	285.9	0.4	11.7
Professional Services	251.8	0.6	11.6
Physician Services	269.2	0.6	11.3
Dentist Services	240.3	0.6	12.1
Other Professional Services	122.9	0.6	11.1
Other Medical Care Services	327.2	0.3	11.9
Hospital and Other Medical Care Services	131.4	0.8	13.1
Hospital Room	412.6	0.6	12.7
Other Hospital and Medical Care Services	130.6	0.8	13.4
Services	274.2	1.9	18.1
Services Less Medical Care	271.0	2.0	18.9

SOURCE: Bureau of Labor Statistics.

TABLE 4

PERCENT CHANGE IN CONSUMER PRICE INDEX (CPI-U):
Cross Classification of Region

	March 1980 to May 1980		May 1979 to May 1980	
	All Items	Medical Care	All Items	Medical Care
North East	1.5	0.7	12.7	9.9
North Central	2.5	1.3	14.3	11.5
West	2.5	1.9	16.7	13.3
South	1.9	1.1	14.3	11.4

	April 1980 to June 1980		June 1979 to June 1980	
	All Items	Medical Care	All Items	Medical Care
North East	1.8	0.7	13.0	9.7
North Central	2.6	0.7	14.4	11.2
West	2.1	1.0	16.1	12.7
South	2.0	1.7	13.9	11.9

Soucre: Bureau of Labor Statistics. Figures obtained from a telephone conversation with a member of the BLS staff.

Table 5

Percent Change in CPI-U, Selected Cities

	April 1980 to June 1980		June 1979 to June 1980	
	Medical Care	All Items	Medical Care	All Items
Atlanta	4.0	2.9	10.3	13.9
Pittsburgh	2.4	2.2	11.0	14.7
Houston	1.2	2.2	11.4	13.2
All Cities	1.0	2.1	11.4	14.3
Dallas-Fort Worth	1.0	2.0	11.7	17.9
Kansas City	1.0	1.6	11.3	12.9
Minneapolis-St. Paul	1.0	0.9	12.0	10.0
Chicago-Northwestern Indiana	0.8	3.4	14.2	16.3
Cleveland	0.7	1.1	9.3	13.7
San Francisco-Oakland	0.5	1.8	12.8	16.7
Buffalo	0.4	0.7	6.2	12.5
Detroit	0.4	3.4	8.6	19.2
New York-Northeastern New Jersey	0.1	1.8	9.8	11.6
Los Angeles-Long Beach-Anaheim	0.0	2.2	13.2	17.5
Philadelphia	0.0	2.1	8.8	13.4
Honolulu	-0.1	0.0	8.2	11.3

Source: Bureau of Labor Statistics. Figures obtained from a telephone conversation with a member of the BLS staff.

Table 6

Percentage Change in the CPI-U,
U.S. city average and selected areas

	March 1980 to May 1980		May 1979 to May 1980	
	Medical Care	All Items	Medical Care	All Items
San Diego, Ca.	3.2	4.4	11.4	18.1
Chicago, Il. - N.W. Ind.	2.7	3.2	13.8	15.7
Baltimore, Md.	2.6	1.7	12.4	15.7
Washington, D.C. - Md. - Va.	2.4	1.0	10.5	11.7
Los Angeles, - Long Beach - Anaheim, Ca.	2.4	3.2	14.1	18.1
Boston, Ma.	2.2	1.2	12.4	13.1
Anchorage, Al.	2.1	1.3	13.7	11.3
Seattle - Everett, Wa.	1.7	2.4	13.2	17.5
St. Louis, Mo.	1.3	1.6	13.5	14.5
U.S. city average	1.2	2.1	11.5	14.4
Detroit, Mi.	1.1	2.3	9.4	16.1
Denver - Boulder, Co.	0.9	1.1	11.1	11.6
New York - North - eastern N.J.	0.9	1.4	10.2	11.4
Portland, Or.	0.9	1.5	14.2	16.6
Milwaukee, Wi.	0.6	3.1	11.9	15.3
Northeast, Pa. (Scranton)	0.3	1.5	10.1	12.2
Philadelphia, Pa.	0.3	2.0	10.1	13.7
Miami, Fl.	0.2	1.6	12.0	15.3
Cincinnati, Oh. - Ky. - In.	0.1	1.5	9.4	13.6

Source: Bureau of Labor Statistics.

AHA Panel Survey: Report on April, 1980 Hospital Performance - See Table 7

According to the National Panel Survey, community hospital expenses and in-patient hospital expenses increased at accelerating rates in April, 1980 as compared to the corresponding month in 1979. About 80 percent of the increase was attributable to higher costs and about 20 percent to increased utilization and intensity.

General hospital admissions of both the population under age 65 and age 65 and over increased at a slower rate n April, 1980 than in April, 1979. (Admissions of the population age 65 and over continued to increase more than twice as fast as admissions for the under 65 population.) However, patient census (in-patient days/days per month) increased more rapidly than in April, 1979 because of an increase in the average length of stay.

The hospital market basket price index accelerated sharply in April due to higher labor (wages and employment) and nonlabor costs. The fastest growing components of the market basket price index were energy, capital and housekeeping supplies.

Hospital bed capacity, as measured by the number of beds set up and staffed, increased more in April, 1980 than in April, 1979. Admissions and patient census more than kept pace with the increase in bed capacity and the occupancy rate rose from 75.1 percent in April, 1979 to 76.8 percent in April, 1980. Slower growth of bed capacity occurred in the Northern and Eastern regions, while faster growth occurred in the South.

TABLE 7

SELECTED HOSPITAL PERFORMANCE INDICATORS: March and April 1979 and 1980.

Inpatient expenses per admission	Percent Change					
	Month of March		Month of April		Year-to-date	
	1979	1980	1979	1980	1979	1980
Inpatient Statistics						
Inpatient expenses	12.2	14.5	11.8	16.8	12.5	15.7
Inpatient expenses per admission or cost per case	10.1	11.8	8.4	14.4	9.3	11.7
Admissions	1.0	2.4	3.2	2.1	2.9	3.6
Average length of stay	0.1	0.5	-3.1	1.1	-2.1	0.3
Over-65 admissions	5.7	7.0	5.7	5.0	4.4	8.2
ALOS 65+	-2.5	1.5	-3.4	1.0	-2.6	0.1
Under 65 admissions	0.5	0.7	2.3	1.0	2.4	1.9
ALOS 0-64	0.8	-1.3	-3.5	0.3	-2.1	-0.8
Births	4.8	1.3	7.6	3.2	5.7	3.0
Surgical operations	2.4	-1.0	5.0	8.2	5.7	5.4
Beds	1.0	0.5	0.5	0.9	0.9	0.5
Census	2.0	2.9	0.1	3.2	0.8	3.1
Hospital Market Basket						
Total market basket	9.7	13.0	9.9	13.0	9.6	12.7
Labor component	8.7	10.5	9.4	10.7	8.8	11.4
Nonlabor component	11.0	16.5	10.7	16.2	10.7	15.6

Source: American Hospital Association, Hospital Data Center, National Hospital Panel Survey, and Office of Policy Studies (Hospital Market Basket). Number 31, p. 5.

Regional Variations in Hospital Performance Indicators in 1978 and 1979 - See Table 8

According to the National Panel Survey, there were significant regional differences in hospital performance indicators in 1978 and 1979. For example, nationally, the growth rate in the cost of a hospital case (in-patient expenses per admission) decreased 1.4 percentage points, from 11.9 percent in 1978 to 10.4 percent in 1979. However, during this same period the cost per case accelerated by 4.7 percentage points in the East South Central region, was relatively unchanged in New England, and declined 3.3 percentage points in the West South central region. Some of the factors responsible for different regional behavior patterns are discussed below.

New England (Conn., Me., Mass., N.H., R.I., Vt.) - Increase in utilization, particularly of the population age 65 and over, was primarily responsible for the acceleration in total expenses in 1979. The cost per case, unlike other regions, did not decelerate, but increased at approximately the same rate as in 1978.

Middle Atlantic (N.J., N.Y., Penna.) - A moderation in the rate of increase in labor costs (wages and employment) and a reduction in bed capacity was largely responsible for the deceleration in total expenses in 1979. Utilization increased at about the same rate as nationally, although utilization growth was concentrated among the population under age 65.

South Atlantic (Del., D.C., Fl., Ga., Md., N.C., S.C., Va., W.Va.,) - A deceleration in costs offset an acceleration in utilization, causing total expenses to decelerate in 1979.

East North Central (Ill., Ind., Mich., Ohio., Wis.) - An acceleration of utilization, primarily among the population under age 65, and higher costs (labor and nonlabor) caused total expenses to accelerate in 1979.

East South Central (Ala., Ky., Miss., Tenn.) - Total expenses accelerated in 1979 as a result of the acceleration in costs (labor and nonlabor) and utilization. This was the only region in which costs per case accelerated more rapidly than in 1978. However, despite the large increase, the cost per case was still 30 percent ($372) below the national average.

West North Central (Iowa, Ka., Minn., Mo., Neb., N.D., S.D.) - The cost per case decelerated significantly in 1979 as a result of a reduced rate of increase in the hospital workforce.

West South Central (Ark., L.A., Okla., Texas) - Costs per case decelerated sharply, primarily due to slower growth of expenses, particularly running from a slower growth of the workforce.

Mountain (Ariz., Colo., Idaho, Mont., Nev., N.M., Utah, Wy.) - Utilization accelerated, primarily due to an increase in the admissions rate of the population age 65 and over. Costs also accelerated primarily due to the acceleration of nonlabor costs.

Pacific (Alaska, Cal., Hawaii, Ore., Wash.) - Utilization increased more rapidly than any other region, except New England. Costs also accelerated due to an acceleration in labor and nonlabor costs. Wages accelerated at an above average rate, in contrast to 1978 when wages increased at a slower rate than in any other region.

Table 8

Regional Variations In
Hospital Performance, 1978, 1979

Table 8A. Growth of Community Hospital Expenses and Utilization by Region

Region	Percent change from previous year					
	Total expenses		Inpatient expenses per admission		Admissions	
	1978	1979	1978	1979	1978	1979
New England	7.9	13.2	7.9	8.0	- 0.7	3.4
Mid-Atlantic	11.6	10.6	11.7	9.6	- 0.7	1.0
South Atlantic	16.1	14.9	13.9	10.0	1.9	4.3
East North Central	12.4	13.7	11.7	11.3	0.1	1.9
East South Central	11.2	17.4	7.1	11.8	3.2	5.2
West North Central	12.7	12.1	13.7	11.9	- 1.7	0.1
West South Central	15.3	13.3	12.0	8.7	2.0	4.0
Mountain	14.4	14.8	11.6	10.2	2.3	4.6
Pacific	13.1	14.4	13.4	12.1	- 0.9	2.1
U.S. Total	12.8	13.4	11.8	10.4	0.4	2.7

Table 8B. Growth of Selected Utilization Indicators by Region

	Percent change from previous year					
	Admissions		Admission rate (per 1,000 population)		65-and-over admissions	
	1978	1979	1978	1979	1978	1979
New England	- 0.7	3.4	- 1.1	3.2	3.8	7.0
Mid-Atlantic	- 0.7	1.0	- 0.3	1.4	4.5	5.1
South Atlantic	1.9	4.3	0.7	3.3	9.9	7.1
East North Central	0.1	1.9	- 0.2	1.7	3.9	3.2
East South Central	3.2	5.2	2.3	4.2	5.5	8.4
West North Central	- 1.7	0.1	- 2.2	- 0.4	1.0	3.9
West South Central	2.0	4.0	0.3	2.0	5.8	4.5
Mountain	2.3	4.6	- 0.5	1.5	6.6	6.4
Pacific	- 0.9	2.1	- 3.0	0.0	2.7	4.8
U.S. Total	0.4	2.7	- 0.4	1.8	4.9	5.3

Table 8C. Growth of Selected Expense Components by Region

	Percent change from previous year					
	Payroll expenses/FTE		FTE personnel		Supplies and services expenses	
	1978	1979	1978	1979	1978	1979
New England	8.0	10.4	- 0.7	1.5	8.4	14.6
Mid-Atlantic	8.1	6.5	2.9	2.4	10.4	12.1
South Atlantic	9.3	9.4	5.0	4.7	16.5	15.0
East North Central	9.0	10.1	3.0	3.5	12.0	13.1
East South Central	8.7	10.2	2.8	6.4	11.3	17.5
West North Central	7.9	10.1	3.8	1.2	12.1	12.1
West South Central	9.6	9.8	5.9	2.6	13.1	13.6
Mountain	8.6	10.4	5.7	3.7	12.0	14.2
Pacific	7.1	9.9	5.3	5.3	11.0	14.1
U.S. Total	8.4	9.3	3.7	3.5	12.0	13.7

Source: American Hospital Association Office of Policy Studies, HOSPITAL PERFORMANCE, Vol. 2, No. 5, May 1980, pp. 2, 4, 5.

For additional information, see the article "Regional Variation in the Growth of Hospital Expenses, 1978-1979" in AHA, HOSPITAL PERFORMANCE, Vol. 2, No. 5, May, 1980, pp. 2-7.

AHA Hospital Cost (HCI) and Hospital Intensity (HII) Indexes - See Table 9

The Hospital Cost Index (HCI) reflects changes in the price of a hospital market basket consisting of 46 procedures, the hospital intensity index (HII), reflects changes in the quantity of these same procedures, and the real service volume index (RSV) adjusts the intensity index (HII) for changes in seasonally adjusted patient days.

Percent Change in Hospital Cost and Intensity Index

Table 9

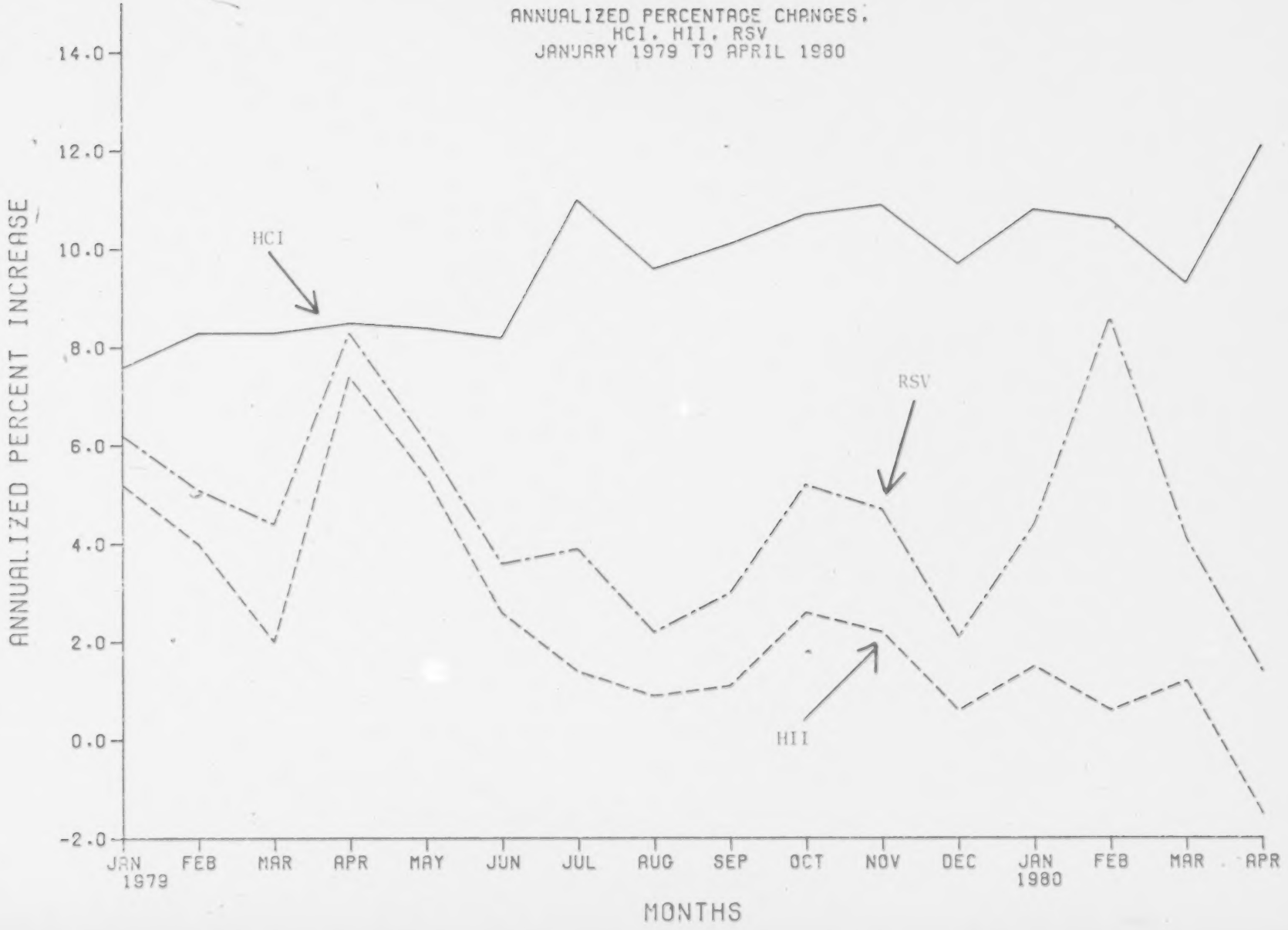
	12 Month Period Ending		
	February 1980	March 1980	April 1980
Hospital Cost Index (HCI)	10.58r	9.30	12.10p
Hospital Intensity Index (HII)	0.57r	1.25	-1.52p
Real Service Volume (RSV)	8.64r	4.14	1.44p

r. revised

p. preliminary

Source: American Hospital Association.

FIGURE 2


ANNUALIZED PERCENTAGE CHANGES.
HCI. HII. RSV
JANUARY 1979 TO APRIL 1980
ANNUALIZED PERCENT INCREASE
14.0
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The Economic Report is a publication of the Health Economics Research Department of the Blue Cross and Blue Shield Associations; Edward S. Mills, Vice President.

For information on The Re-Industrialization of America and its Impact on Plans, A Comparison of the Impact of the 1973-75 Recession and the Current Recession on Plan Activities, and Current Medical Care Price, Utilization and Cost Statistics, contact Dr. Rachel Golden, Research Economist, (312) 440-5539. Other requests, contact Linda M. Krasovskis, Editorial Assistant, (312) 440-6787.

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August/September 1980

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EXECUTIVE SUMMARY

The economic environment for 1980-81 will be characterized by sluggish economic growth, deterioriating corporate profits, high unemployment and increased hospital utilization. At the same time, there will be pressure to expand health care benefits while holding down the cost of health care services. This situation will challenge Plans' ability to provide innovative benefits and reduce administrative cost while still providing adequate service to subscribers.

Plans may have a difficult time increasing market penetration. Competitors are able to provide accounts with flexible benefit packages and financial arrangements. High capital cost and little change in real consumer spending will slow the birth of new businesses. Meanwhile, employment growth is expected to be minimal.

The growth that does occur in the economy will be predominately in the service producing sector, (e.g., services, trade, finance and real estate). Meanwhile, employment in manufacturing is expected to decline.

Wage earners, especially unions, will press for benefits that cover ordinary out-of-pocket expenses. Businesses will look to protect their bottom line by pressing for programs that have incentives to reduce utilization and expensive medical care. States will mandate additional benefit coverage.

Union activity will stress recruiting new members by emphasizing its ability to obtain wage increases and better health benefits. Unions will concentrate

their efforts on employees in public service, hospitals, universities and other professional groups. The thrust of these efforts will be in the South and Southwest where unions presently are not strong.

Plan financial positions will be threatened with rising utilization and increased medical care costs. Because of market pressures and, in some cases, state insurance departments, Plans may find it difficult to raise premiums. The movement of interest rates is not expected to help Plans offset this situation with investment income. Thus, many Plans may operate at an underwriting loss. However, high interest rates might cause hospitals to attempt to reduce cash requirements by seeking faster payments from Plans. Businesses may also attempt to improve their cash flow position by slowing premium payments or negotiating tougher contracts which preserve their cash.

Both President Carter and Governor Reagan have proposed tax bills that stimulate employment, particularly in the manufacturing sector. Government will also attempt to decrease government spending and reduce the tax burden on business and individuals. It is also likely to reduce the rate of increase of entitlement programs.

Any fiscal policy aimed at promoting economic growth, full employment, and price stability is also likely to accelerate inflation. High inflation, especially in medical costs is likely to encourage business, labor and the government to seek relief from rising medical care cost through legislation. Thus, future fiscal policy will have both positive and negative effects on Plan competitiveness.

MIDYEAR ECONOMIC OUTLOOK FOR 1981

Overview

According to most economists, in 1981 the economy will be recovering from the short, sharp recession of 1980. That recovery is likely to be sluggish. However, some economists think that there is a possibility of a double-dip recession due to high interest rates and a recession abroad. Inflation is not expected to moderate appreciably, while premium costs are likely to accelerate. Some economists are predicting that personal consumption of medical care services and federal spending for Medicare and Medicaid will increase more rapidly than the GNP. (See Table 1.) When adjusted for inflation, health care spending in 1981 is likely to increase by about 2 percent over 1980. However, the sluggish recovery is likely to curtail the growth of Plan enrollment and new benefits and to limit improvement in the financial condition of Plans. Thus, the economic environment for 1981 suggests that Plans focus on productivity gains rather than rely exclusively on expansion in order to strengthen their financial condition.

Table 1

YEAR-TO-YEAR INCREASES IN GNP AND MEDICAL CARE SPENDING

(Seasonally adjusted at annual rates)

	1979	1980	1981
Gross National Product	11.3%	7.8%	9.8%
Personal consumption of medical care services	12.3	12.9	10.6
Federal transfers to persons for hospital and supplementary medical insurance benefits	18.9	14.5	11.2

Source: Conversation with staff of Townsend-Greenspan, Inc. in August 1980.

Market Penetration

Future enrollment gains will occur as a result of taking business away from competitors, obtaining contracts from newly formed groups or nongroup subscribers, and/or increases in employment in Plan accounts.

COMPETITORS - The economic environment in 1981 is not likely to foster significant enrollment gains at the expense of competitors. Most economists are predicting continued deterioration in corporate profits and double-digit increases in premium costs in 1981. (See Table 2.) Businesses may try to reduce their health benefit bills by switching insurers, self-insuring, obtaining flexible benefits and/or promoting greater use of alternative delivery systems. Businesses are also likely to require cost containment documentation from insurers.

Plan competitors are prepared to protect and expand their market share. Many of them provide flexible benefits, such as disability, dental, vision care, preventive care and rehabilitation services. They also offer financial flexibility, such as ASOs for businesses that choose to self-insure. They have packaged benefit plans which may include savings if an account purchases several types of insurance, e.g., life, disability and health. In recent months several life insurance companies have been reducing the maturities of their investments, thus increasing their cash flow as well as their ability to be aggressive in the health benefit market.

Table 2

YEAR-TO-YEAR CHANGES IN CORPORATE PROFITS

	1978	1979	1980	1981
Pre-tax profits	16.3%	14.9%	-12.7%	-8.6%
After-tax profits	16.3	18.6	-13.0	-4.4
Adjusted after-tax profits*	7.6	3.0	-18.2	17.6

* Adjusted to exclude inventory profits and to allow depreciation at replacement cost.

Source: HARRIS ECONOMICS, August 15, 1980.

NEW BUSINESSES/NONGROUP - There is not likely to be significant growth in contracts from newly formed groups and nongroup subscribers. The high cost of capital, coupled with the expectation of little or no change in real consumer spending is likely to prevent a substantial increase in the number of new businesses. New nongroup business is also not likely to expand rapidly because of the expected high rate of unemployment and the poor condition of consumer cash balances. (See Table 3.) Unemployment is expected to increase in the months ahead, and then to remain at high levels in 1981. Many unemployed workers are young and healthy, and may not be willing, or financially able, to purchase nongroup coverage. The divorce rate is expected to continue to rise. This could boost the number of nongroup subscribers. However, some health insurers are providing non-working ex-spouses with coverage at group rates.

Table 3

YEAR-TO-YEAR PERCENT INCREASES IN PERSONAL INCOME

	1978	1979	1980	1981
Personal income	12.1%	12.0%	9.1%	8.6%
Disposable income	11.7	11.4	9.0	8.9
Personal outlays	11.8	11.8	9.4	8.5
Personal savings	10.9	2.4	-0.8	18.8
Savings rate	5.0	4.5	4.1	4.5

Source: Harris Economics, August 15, 1980.

GROWTH IN PLAN ACCOUNTS - Increases in Plan enrollment because of additional employees in Plans accounts are likely to be marginal. Employment growth is expected to be slight, despite an expanding economy. (This is not unusual in the early stages of a recovery. A significant increase in civilian employment is not projected before 1982.)

Even though employment in some Plan accounts may increase in 1981, Plan enrollment may show little or no change. For example, many auto and steel workers are likely to be recalled in the near future. Most laid-off workers in those industries did not have their health benefits cancelled. Thus, increases in employment will not translate into corresponding increases in Plan enrollment. Furthermore, some economists are predicting that employment in some industries which are also major Plan accounts, e.g., automobile, automobile-related and steel, will not regain pre-slump levels. Some analysts say that approximately 350,000 jobs in automobile-related industries have already permanently disappeared. If this estimate is correct, Plan enrollment will probably be reduced.

In the longer run, some Japanese automobile manufacturers are expected to open plants in the U.S. The UAW is happy about the increase in potential members. However, the UAW has had difficulty in organizing Japanese companies, e.g., Kawasaki and Honda motorcycle plants and a California dock operation of a Mazda distributor. UAW officials say that they are more comfortable working with "known" U.S. management, whose behavior patterns they understand. Since some automobile workers may not be covered by the UAW contract, Plans should be prepared to deal directly with foreign managements.

Table 4

POPULATION, LABOR FORCE AND EMPLOYMENT FORECASTS

(in millions)

	1978	1979	1980	1981	1982
Population, total	218.6	220.5	222.6	224.8	227.0
Males 16-24	17.5	17.7	17.7	17.6	17.3
Females 16-24	18.3	18.4	18.4	18.3	18.0
Males 25-54	38.6	39.4	40.3	41.1	42.0
Females 25-54	41.3	42.0	42.9	43.8	44.7
Total 55 and older	43.2	44.1	44.9	45.7	46.5
Civilian labor force, total	100.4	102.9	105.0	107.3	111.3
Males 16-24	13.1	13.3	13.3	13.3	13.5
Females 16-24	11.3	11.5	11.5	12.0	12.9
Males 25-54	36.4	37.2	37.7	38.2	39.0
Females 25-54	25.0	26.2	27.5	28.9	30.8
Total 55 and older	14.6	14.8	14.9	14.9	15.2
Number of employees, total	86.43	89.49	90.53	92.23	96.31
Manufacturing	20.47	20.99	20.34	20.27	21.30
Construction	4.26	4.67	4.38	4.41	5.17
Other private	46.22	48.21	49.57	51.20	53.28
Civilian Government	15.48	15.61	16.25	16.35	16.56
Self-employed	7.95	7.46	6.49	6.38	7.04
Number unemployed	6.02	5.97	7.93	8.70	7.90

	1978	1979	1980	1981	1982
Unemployment rate, total	6.0%	5.8%	7.6%	7.5%	N/A
Manufacturing	5.4	5.6	N/A	N/A	N/A
Married men	2.7	2.7	N/A	N/A	N/A

Source: Conversations with EVANS ECONOMICS staff in August 1980.

Employment Growth

In the past decade, and in all regions of the country, the greatest growth in employment occurred in the services sector. According to David Birch, MIT professor, "Gains in the service sector accounted for much if not all of the growth in rapidly growing areas like Colorado, Arizona, and Florida and were the only thing keeping declining states (like Connecticut, Massachusetts, New York, New Jersey, and Rhode Island) alive, particularly during the period 1974-76."* Furthermore, Birch finds that about 60 percent of new jobs are generated by firms with 20 or fewer employees; large firms (those with 500 or more employees) generate less than 15 percent of all new jobs. (See Table 5.) In addition, he says that employment in smaller firms is more likely to expand while employment in larger firms is more likely to contract. (The greatest employment growth is likely to occur in young firms, up to four years old.) If Birch is correct, and if this trend continues in the 1980s, most employment gains are likely to take place in small and young service establishments. Some commercials are already gearing their marketing strategies to smaller groups.

* David Birch, The Job Generation Process, M.I.T. Program on Neighborhood and Regional Change", Cambridge, Mass. 1979, p. 24.

Table 5

PERCENTAGE OF TOTAL JOBS GENERATED BY SIZE AND STATUS FOR REGIONS AND THE U.S. BETWEEN 1960 AND 1976

		Number of Employees					
Region	Ownership	0-20	21-50	51-100	101-500	Over 500	Total
North East	Indep.	129.1%	-11.2%	-22.3%	-21.1%	24.3%	98.8%
	HQ/Br	36.4	10.5	1.3	- 6.6	-32.8	8.8
	Par/Sub.	11.6	7.2	3.6	- 5.5	-24.4	- 7.6
	Totals	177.1	6.5	-17.4	-33.3	-32.9	100.0
North Central	Indep.	52.8%	4.5%	0.3%	- 2.8%	2.9	57.7
	HQ/Br	12.4	5.8	3.8	4.9	13.1	39.9
	Par/Sub.	2.0	1.7	1.2	1.0	- 3.5	2.4
	Totals	67.2	12.0	5.2	3.1	12.4	100.0
South	Indep.	42.7%	5.7%	1.5%	0.0%	0.4%	50.1%
	HQ/Br	9.3	4.0	2.9	7.4	16.7	40.3
	Par/Sub.	1.5	1.5	1.1	2.0	3.3	9.6
	Totals	53.5	11.2	5.5	9.4	20.4	100.0
West	Indep.	47.8%	5.9%	2.2%	1.9%	2.9%	60.8%
	HQ/Br	10.0	4.3	3.0	6.2	8.6	32.0
	Par/Sub.	1.7	1.4	1.1	1.8	1.8	7.2
	Totals	59.5	11.6	6.3	9.3	13.3	100.0
U.S.	Indep.	51.8%	4.4%	0.0%	- 1.5%	3.1%	57.8%
	HQ/Br	11.9	4.9	3.1	5.6	10.6	36.1
	Par/Sub.	2.3	1.9	1.3	1.1	- 0.5	6.1
	Totals	66.0	11.2	4.3	5.2	13.3	100.0

Total jobs generated in each region are: Northeast (410,890), North Central (1,674,282), South (2,873,619), and West (1,800,112).

Source: David Birch, The Job Generation Process, M.I.T. Program on Neighborhood and Regional Change, Cambridge, Mass., 1979, p. 30.

Economists are predicting that in 1981 employment growth will continue to be greatest in the services sector, e.g., services, trade, finance, insurance and real estate. Construction employment is expected to increase moderately while manufacturing employment is expected to decline. Estimates of employment in some industries in the goods producing sector and number of establishments in 1977, the latest census year, appear in Table 6. Other employment and demographic information appears in the appendix.

Table 6

NUMBER OF ESTABLISHMENTS AND FORECASTS OF EMPLOYMENT IN THE GOODS-PRODUCING SECTOR

	Number of Establishments	Number of Production Workers (000)			
	1977	1979	1980	1981	1982
Manufacturing					
Foods	24,294	1176.6	1157.4	1152.0	1155.9
Tobacco products	233	52.9	53.6	53.7	53.2
Textile mill products	6,702	777.0	748.0	740.4	737.8
Apparel products	23,387	1122.1	1093.3	1072.0	1042.3
Lumber and wood products	32,246	646.5	583.9	639.7	741.6
Furniture and Fixtures	9,128	398.2	361.6	317.3	328.9
Paper and Allied Products	6,231	541.6	521.8	528.5	542.3
Printing and publishing	44,651	702.3	712.6	716.1	725.4
Chemicals and allied products	11,513	636.9	630.5	637.3	657.2
Petroleum products	2,067	139.5	119.8	125.7	128.1
Rubber and plastic products	10,660	600.9	551.5	548.5	577.0
Leather and leather products	2,875	207.2	198.4	195.0	186.4
Stone, clay and glass products	16,619	560.5	521.4	538.8	558.4
Primary metals	7,111	978.1	875.5	863.0	889.9
Fabricated metal products	31,118	1306.0	1211.3	1242.8	1316.0
Nonelectrical machinery	44,463	1616.1	1588.8	1510.8	1596.4
Electrical machinery	13,565	1378.4	1356.0	1385.2	1530.6
Transportation equipment	9,147	1418.8	1220.2	1234.0	1306.5
Instruments	6,854	421.0	403.3	415.6	453.9
Miscellaneous manufacturing	15,580	344.4	319.2	315.5	327.7
Mining					
Metal mining	897	74.8	73.9	79.9	82.0
Coal mining	4,418	216.2	215.9	234.5	257.1
Oil and gas extraction	15,593	327.5	369.8	392.8	425.3

	Number of Establishments	Number of Production Workers (000)			
	1977	1979	1980	1981	1982
Utilities					
Utilities	15,093	659.3	678.0	686.7	709.8

Source: Employment estimates were obtained from EVANS ECONOMICS staff in August 1980. Number of establishments were obtained from Bureau of the Census, County Business Patterns 1977, CBP-77-B October 1979

Health Benefits

The financial condition of business - deteriorating profits and accelerating labor and premium costs - are likely to prevent business from expanding benefits rapidly. Labor costs are expected to increase about 9 to 10.5 percent in 1981. In addition, some businesses may allocate a higher priority to improving pensions. They may freeze, or reduce, the portion of the fringe benefit dollar allocated to health. On the other hand, many businesses recognize that a way to restrain the growth of health care costs is to provide benefits which contain incentives to reduce utilization and expensive medical care. Thus, some businesses are likely to modify their benefit packages in 1981 to include benefits which encourage healthier life-styles, second opinions, lab tests outside a hospital, rehabiliation services, etc. Such a program was started by Blue Shield of California. Under this progam employees are provided cash incentives for avoiding unnecessary doctor bills. However, workers will probably be more interested in additional benefits which protect them from inflation and taxes by covering ordinary out-of-pocket medical care expenses, such as dental and vision care. Thus, the growth of new benefits in 1981 is likely to be largely a mixture which reflects the desire of business

to protect its bottom line by providing cost effective medical benefits, and the desire of workers for benefits that cover ordinary out-of-pocket expenses.

Since few major labor contracts expire in 1981, union membership recruitment will be a high priority. Wages of union workers have outpaced those of nonunion workers. Union organizers are likely to emphasize their ability to obtain wage increases and health benefits comparable to those received by automobile and steel workers.

The major thrust of labor's organizing effort is likely to be in the service sector, e.g., public services, hospitals and insurance, and in the South and Southwest where organized labor is not strong. For example, the UAW has been actively seeking out professional groups, including health care workers, office and clerical workers at universities and service businesses in New York. For workers who are unionized, bargaining efforts are likely to focus on improving cost-of-living adjustments, job security, pensions, OSHA protection and obtaining health benefits comparable to those in the UAW or USW. In general, unions oppose having employees kick in more each month for premiums or paying larger deductibles on medical bills. However, some unions have recently agreed to higher deductibles in exchange for dental, outpatient, and vision care benefits.

Business is likely to be sympathetic to worker demands for improved health benefits that cover out-of-pocket expenses, such as dental costs, vision care and lab tests. However, its poor financial condition is likely to make it cautious about expanding benefits, especially if it suspects that the new benefit may increase at an uncontrollable rate.

Some expansion in benefits is likely to occur as a result of state governments' increasing the regulation of the health insurance industry, particularly through mandating additional benefit coverage.

Some switching from low to high option plans is likely to occur if the birth rate continues upward. On the other hand, the recession has stripped many two-income families of a paycheck, causing painful adjustments. Thus, some individuals may downgrade their policies.

Plan Financial Health

The economic environment may not be right for the financial health of Plans. Inflation in the medical care sector is not likely to moderate, while utilization is likely to continue to increase. Interest rates may not generate sufficient income to offset pressures on increasing claim costs. However, 1981 is not an election year. Political pressures to deny, or delay, Plan requests for rate increases may be reduced sufficiently to permit state insurance commissioners to grant requests for rate increases.

MEDICAL CARE COSTS - Higher labor and nonlabor costs are likely to cause medical care prices to continue to increase at current rates. In recent months the increases in the prices of physician services, drugs and hospital labor costs have accelerated. The severe nursing shortage is putting upward pressures on hospital labor costs, which account for about 60 percent of total hospital costs. That pressure is not likely to abate in 1981. In addition, some analysts are predicting that capital spending by the hospital industry will accelerate, despite to high interest rates. Physician services are likely

to increase by about 10.5 to 11.5 percent, and hospital prices by 12 to 13 percent in 1981. Inflation, as measured by the CPI, is expected to moderate because of a slowdown in the rate of increase in housing, energy and transportation prices. (See Table 7.) Thus, in 1981, medical care prices may be increasing at the same, or a higher rate than the CPI, in contrast to behavior in 1979 and 1980. However, medical care prices are still likely to increase at a slower rate than the price of a home (15 percent) or energy (12 to 16 percent).

Table 7

ESTIMATED PERCENT INCREASES IN PRICES AND HOSPITAL UTILIZATION
(Annual rates)

	1978 a/	1979 a/	1980	1981	1982
Consumer Price Index	7.7%	11.3%	13.1 % b/	9.6 % b/	N/A
Medical care	8.4	9.3	11.0-12.0 c/	10.5-11.5 c/	9.5-10.5 c/
Medical care services	9.2	9.7	11.5-12.5 c/	11.0-12.0 c/	10.0-11.0 c/
Physician services	8.3	9.2	10.5-12.0 c/	10.5-11.5 c/	N/A
Hospital and other medical care services	N/A	10.7	12.0-13.0	12.0-13.0 c/	N/A
AHA Hospital Market Basket	8.7 d/	10.5 d/	12.1 d/	10.6 d/	N/A
Adjusted Admissions *	0.9 d/	2.8 d/	3.0 d/	2.0 d/	N/A

* Inpatient admissions adjusted to reflect outpatient services.

Sources: a/ Bureau of Labor Statistics
b/ BLUE CHIP ECONOMIC INDICATORS, September 10, 1980, p. 3
c/ Estimates from some economic consulting organizations
d/ American Hospital Association, Office of Policy Studies, POLICY BRIEF, NO. 27, September 24, 1980, p. 6.

UTILIZATION - Several Plans have indicated that they expect utilization, measured by admissions, to continue to increase in 1981. Among the possible

causes of increased utilization are high unemployment, illnesses related to stress (stemming from job insecurity, financial pressures, the increase in the number of females who are balancing careers, families and marriage) and automobile accidents (due to a larger number of small cars, which are believed to be less safe on the road). In addition, high inflation and the elimination of mandatory retirement before age 70 is likely to increase the number of the working aged, who are high risk customers. The birth rate has been rising recently, particularly for older women, who are likely to have more complicated deliveries. Some epidemiologists expect an increase in utilization by Viet Nam veterans who become sick or whose children suffer birth defects as a result of exposure to Agent Orange.

Increased utilization may put pressure on claims processing facilities. Additional staff may be needed to handle the additional service demands promptly and efficiently. Thus, Plans administrative costs may increase in 1981.

PREMIUMS - The combination of higher medical care prices, increased utilization and higher administrative costs is likely to cause claim cost trends to increase by approximately 13 to 18 percent in 1981. Premium increases may be restrained by market pressures and a possible CWPS third-year price standard. Several Plans may continue to experience underwriting losses.

INTEREST RATES - Movements of interest rates are always difficult to predict. (They have been especially hard to predict this year because of wide swings in inflation expectations.) Many analysts expect interest rates to peak in October or November and then to drift downward until about February

1981. Furthermore, they expect interest rates to increase modestly in 1981. Short-term rates are expected to increase less than long-term rates. In mid-September, Townsend-Greenspan predicted that the prime rate would be in the 10 percent range by mid-1981, and then would back up to 10 1/2 to 11 percent by year-end 1981, the federal funds rate would be about 8 1/2 percent by mid-1981 and about 9 percent by year end 1981, and corporate AAA bond rates would be less than 11 percent in mid-1981 and over 11 percent by year end.

The Townsend-Greenspan forecast suggests that Plans which are under financial pressures many not be able to offset underwriting losses by increases in investment income and that pressure on their reserves may continue. In addition, high interest rates may cause hospitals to attempt to reduce cash requirements by seeking faster payments from Plans. Businesses may also attempt to improve their cash flow position by slowing premium payments or negotiating tougher contracts which preserve their cash flow.

Future Economic Policies

Business, political and economic leaders recognize that the nation has very serious economic problems. The problems are inflation and low productivity growth. Moreover, they recognize that the next few years will be very difficult ones, especially the year ahead. Government must implement economic policies to dampen inflationary psychology and promote investment and savings. Otherwise the economic pie will not increase enough to provide all socio-economic groups with a larger share. However, to dampen inflationary psychology and to promote investment and savings, will require economic policies which are likely to be politically unpopular. A "quick fix", e.g., mandatory controls, is likely to aggravate the problem.

TAX BILLS - Both Reagan and Carter said that the centerpiece of a tax bill should be a business tax cut which increases depreciation allowances and provides business with some cash flow to "reindustrialize" or "revitalize". (Taxes are likely to be reduced $30 to $40 billion, with 50 percent of that amount representing reductions in business taxes and 50 percent representing reductions in personal income taxes. The tax bill is likely to be enacted in mid-1981, retroactive to January 1, 1981.) If Reagan is elected, there will probably be an across-the-board reduction in personal income tax rates. If Carter is elected there will probably be a tax credit for employers and employees to offset the January 1st increase in the Social Security tax rate from 6.13 percent to 6.65 percent, but not the increase in the tax base from $25,900 to $29,700. Most analysts believe that a reduction in the marriage penalty tax will be included in the 1981 tax bill, regardless of who is president. The reduction in the marriage penalty tax would probably reduce the tax on earnings of the lower paid spouse by not more than $3000.

The business tax cut and the reduction in the marriage penalty tax are likely to benefit Plans because they will stimulate employment. The Carter tax credit for Social Security is likely to reduce but not eliminate the advantages to both employers and employees in increasing health benefits rather than increasing cash wages.

GOVERNMENT SPENDING - There is also likely to be increased bipartisan support in Congress in 1981 to reduce the deficit (which will be approximately $63 billion in FY 1980) by reducing the rate of growth of government spending. Thus, Congress is not likely to increase social programs or expand Medicare benefits.

There are many in Congress who would like to reduce government spending as a share of GNP. Supporters include those who want to reduce the deficit as well as those who believe that a reduction in fiscal "drag", or the tax burden, would lead to an increase in investment and productivity. In order to reduce government spending and impose fiscal discipline, Congress would probably need to limit the growth of entitlement programs. See Table 8 for a list of entitlement programs and their estimated cost in 1981.

Table 8

MAJOR ENTITLEMENTS

Following is a list of major entitlement programs, arranged by budget function, with projected spending in fiscal 1981 (in billions of dollars).

Defense	
Military retirement pay*	$ 13.7
Agriculture	
Farm price supports	1.6
Education, training, employment and social services	
Student loan insurance*	1.4
Social services grants	3.1
Health	
Medicaid*	15.7
Medicaid	39.0
Income security	
Black lung disability*	2.0
Social Security	137.3
Railroad retirement	5.2
Civil service retirement	17.1
Federal unemployment benefits*	1.3
Unemployment trust fund	16.3
Supplemental security income*	7.0
Aid to families with dependent children	7.5
Earned income tax credit	1.6
Child nutrition*	3.6
Veterans' benefits and services	
Veterans' compensation*	8.4
Veterans' pension*	3.5
GI bill	2.0
General purpose fiscal assistance	
General revenue sharing*	6.9
Other entitlements	5.3
Total	$ 299.5

* programs requiring annual appropriations

SOURCE: Senate Budget Committee

Any budget cut is politically difficult. For example, Rep. James Jones of Oklahoma, and a member of the House Ways and Means Committees, said of the last round of budget cuts that "It was bloody. It took political courage to cut spending for those who were going to redistrict you shortly."

Congress is not likely to renege on its commitments to those who are entitled to benefits. However, Congress is likely to shift as much of the funding of those programs as possible to off-budget spending or to the private sector. In the case of health, that could mean having the federal government become the secondary insuror of the working aged, veterans and Medicare beneficiaries who have been in automobile accidents and whose automobile insurance covers medical costs; or by reimbursing hospitals for malpractice insurance on the basis of the experience of Medicare patients, rather than the share of Medicare patients in a hospital's population. (The latter would probably cause hospitals to shift a larger portion of malpractice insurance to Plans and commercials.)

Government is also likely to try to reduce the rate of increase in the cost of entitlement programs in future budgets. For example, it might impose caps on Medicare reimbursements or continue to infringe on the prime Medicare contract through attempts to expand competitive bidding and eliminate the provider nomination process.

Fiscal policy to promote economic growth and price stability in 1981 is likely to accelerate inflation in the short-run. There could be a backlash against rising medical care costs from politicians and businesses, who want to restrain the growth of their health care bill, and from labor, which thinks

that wages and other fringe benefits could increase more rapidly if the cost of existing health care benefits could be moderated. The result could be further pressure to enact legislation to provide tax incentives to those with employer-provided health benefits who choose low-option health benefit plans or HMOs.

Thus, the effort to restrain the growth of government spending, or to reduce it as a share of GNP, is likely to be an attempt by Congress to transfer some health care costs to third party payers. If successful, Plan claims costs, as well as administrative expenses, could increase. However, market pressures or a third-year CWPS price standard may prevent Plan income from rising enough to offset additional costs. If so, Plan reserves could be adversely affected. Thus, fiscal policy in 1981 may have some benefits, e.g., it is likely to benefit enrollment by stimulating employment. However, it may also have some longer term costs in terms of fiscal viability of the system.

The U.S. Consumer: A Statistical Profile State-by-State

STATE	Population	Percent under age 17	Percent 18-64	Percent 65 and over	Birth Rate per 1,000	Death Rate per 1,000	Marriage Rate per 1,000	Divorce Rate per 1,000	Net migration 1970-1977 (thousands)	Number of households (thousands)	Percent annual average change (1970-1978)	Trends in birth*	Trends in marriage*	Trends in divorce*	Trends in net migration**	Trends in household formation*	STATE
	3.7	30.5	58.6	10.9	16.8	9.4	12.4	6.4	50	1,252	2.3	U	L	L	M-P	U	Alabama
	.4	36.0	61.5	2.5	20.6	4.0	12.6	8.8	68	119	5.0	L	L	U	P-P	U	Alaska
	2.4	31.2	57.4	11.4	18.2	7.9	11.7	7.2	367	813	5.0	U	L	D	P-P	U	Arizona
	2.2	29.8	56.6	13.4	16.7	10.0	11.2	9.0	135	765	2.6	L	L	U	M-P	U	Arkansas
	22.3	28.0	61.9	10.1	15.9	7.8	6.8	6.0	809	8,401	3.0	U	D	D	PP-P	U	California
Colorado	2.7	29.5	61.8	8.7	16.4	6.8	11.5	7.8	255	955	3.9	U	U	U	P-P	U	Colorado
Connecticut	3.1	27.2	61.6	11.2	11.6	8.2	7.4	3.9	- 23	1,080	1.8	L	D	L	P-M	D	Connecticut
Delaware	.6	29.0	61.6	9.4	14.8	8.1	6.9	5.2	5	199	2.3	L	L	D	PP-P	D	Delaware
Florida	8.6	25.7	56.7	17.6	13.1	10.9	10.6	7.4	1,492	3,275	4.4	U	U	D	P-P	U	Florida
Georgia	5.1	31.0	59.7	9.3	16.8	8.5	13.3	6.1	136	1,659	2.6	U	U	L	P-P	U	Georgia
Hawaii	.9	30.7	61.9	7.4	18.9	5.0	11.5	5.1	37	272	3.5	U	L	D	P-P	U	Hawaii
Idaho	.9	32.5	57.5	9.9	22.0	7.5	16.0	7.0	77	293	3.5	U	U	U	M-P	U	Idaho
Illinois	11.2	29.4	59.9	10.7	15.8	9.2	9.6	4.4	-327	3,929	1.4	U	D	D	M-MM	U	Illinois
Indiana	5.4	30.2	59.3	10.5	16.0	8.6	10.6	6.3	-126	1,808	1.7	U	L	U	M-MM	U	Indiana
Iowa	2.9	29.0	57.9	13.1	15.6	9.3	9.2	3.8	- 36	1,027	1.6	U	U	U	MM-M	U	Iowa
Kansas	2.3	27.9	59.5	12.6	15.9	9.2	10.2	5.4	- 19	851	1.9	U	L	L	MM-M	U	Kansas
Kentucky	3.5	30.0	58.9	11.1	17.0	9.7	9.3	4.5	81	1,179	1.4	U	L	L	M-P	U	Kentucky
Louisiana	4.0	32.8	57.9	9.3	19.1	8.8	9.9	3.3	26	1,288	2.5	U	U	L	M-P	U	Louisiana
Maine	1.1	29.7	58.1	12.2	14.9	9.3	10.5	5.2	51	371	2.5	U	D	L	M-P	U	Maine
Maryland	4.1	28.6	62.5	8.9	13.5	7.8	10.9	4.0	40	1,416	2.3	U	L	U	PP-P	D	Maryland
Massachusetts	5.8	27.1	60.8	12.1	11.8	9.0	7.3	2.9	- 54	2,020	1.7	L	L	U	P-M	U	Massachusetts
Michigan	9.2	30.5	60.1	9.4	15.2	8.1	9.4	4.7	-229	3,102	1.7	U	U	U	P-M	U	Michigan
Minnesota	4.0	29.5	58.9	11.6	15.2	8.1	8.3	3.5	- 6	1,386	2.2	U	L	U	MM-M	U	Minnesota
Mississippi	2.4	33.7	55.1	11.2	19.0	9.6	11.2	5.3	8	765	2.2	U	L	U	M-P	U	Mississippi
Missouri	4.9	28.2	59.5	12.3	15.2	10.2	10.9	5.3	- 12	1,748	1.7	U	L	L	P-M	U	Missouri
Montana	.8	30.5	59.2	10.3	17.5	8.4	9.9	6.2	32	278	3.0	U	L	D	M-P	U	Montana
Nebraska	1.6	29.1	58.0	12.9	16.1	9.2	8.6	3.9	3	556	1.9	U	L	U	M-P	U	Nebraska
Nevada	.7	36.0	61.7	8.3	16.1	7.7	163.8	16.2	112	243	5.1	U	D	D	P-P	D	Nevada
New Hampshire	.9	29.7	58.1	12.2	14.2	8.6	10.5	5.2	79	298	3.4	U	L	L	P-P	U	New Hampshire
New Jersey	7.3	28.1	60.7	11.2	12.8	9.0	6.9	2.8	- 67	2,520	1.5	L	D	L	P-M	D	New Jersey
New Mexico	1.2	33.4	56.0	8.6	19.3	6.8	13.8	7.7	80	397	3.8	U	L	L	M-P	U	New Mexico
New York	17.7	27.6	60.6	11.8	13.4	9.4	7.5	3.1	-863	6,441	1.0	L	D	L	M-MM	D	New York
North Carolina	5.6	29.4	60.7	9.9	15.5	8.4	7.9	4.5	132	1,877	2.6	U	U	U	M-P	U	North Carolina
North Dakota	.7	30.4	57.6	12.0	17.5	8.0	8.7	3.0	- 2	217	2.2	U	D	U	MM-M	U	North Dakota
Ohio	10.7	29.4	60.1	10.5	15.1	9.1	9.3	5.4	-468	3,709	1.5	U	L	L	M-MM	U	Ohio
Oklahoma	2.9	28.6	59.0	12.4	19.1	9.5	15.0	7.8	139	1,051	2.6	U	U	L	P-P	U	Oklahoma
Oregon	2.4	28.2	60.1	11.7	15.8	8.6	8.5	6.9	199	868	3.3	U	L	U	P-P	U	Oregon
Pennsylvania	11.8	27.2	60.4	12.4	13.0	10.1	7.7	3.2	-272	4,130	1.3	L	D	U	MM-M	U	Pennsylvania
Rhode Island	.9	27.6	59.8	12.6	12.3	9.7	7.6	3.7	- 36	326	1.3	U	U	U	P-M	L	Rhode Island
South Carolina	2.9	31.5	59.7	8.8	17.4	8.4	17.8	5.7	100	944	3.0	U	L	L	M-P	U	South Carolina
South Dakota	.7	30.3	56.8	12.9	17.5	9.1	15.0	3.5	- 13	235	1.9	U	D	U	MM-M	U	South Dakota
Tennessee	4.4	29.1	59.9	11.0	15.5	9.4	12.9	6.4	170	1,494	2.5	U	U	U	M-P	U	Tennessee
Texas	13.0	31.0	59.3	9.7	17.9	7.8	12.4	6.4	757	4,433	3.1	U	L	L	P-PP	U	Texas
Utah	1.3	37.0	55.2	7.8	29.9	6.0	11.9	5.5	45	396	3.4	U	D	U	M-P	U	Utah
Vermont	.5	29.8	58.9	11.3	14.5	8.7	9.9	4.4	17	164	2.6	L	L	U	P-P	U	Vermont
Virginia	5.1	28.6	62.3	9.1	14.5	7.8	11.3	4.2	191	1,749	2.8	L	U	L	P-P	U	Virginia
Washington	3.9	28.5	60.9	10.6	15.6	8.2	12.0	7.3	107	1,392	2.8	U	L	L	P-P	U	Washington
West Virginia	1.9	29.1	61.8	9.1	16.2	10.4	9.4	5.2	43	645	2.0	U	L	U	M-P	U	West Virginia
Wisconsin	4.7	29.4	58.9	11.7	14.8	8.5	8.0	3.1	34	1,598	2.2	U	U	L	P-P	U	Wisconsin
Wyoming	.4	30.9	60.6	8.5	22.0	7.5	14.8	7.6	48	147	4.1	U	U	U	M-P	U	Wyoming
U.S. Average		29.0	59.6	11.4	15.4	8.8	10.1	5.0			2.3						U.S. Average

1978 data unless noted otherwise.

*U = trending upward, L = level, D = Trending downward

**M = minus; P = plus. A double M or P = a heavy outflow or inflow. The first letter or letters are for the 1960-70 period, the second are for the 1970-77 period. Thus, for example, Alabama had a net outflow in the 1960-70 period and a net inflow in the subsequent period. California experienced a net inflow in both periods, but it was much heavier in the first. Conversely, the net outflow from Iowa has been ebbing.

Source: Update/The American States, March 31, 1980, pp. 4, 5.

EMPLOYMENT TRENDS STATE-BY-STATE
(Nonagricultural Employment in Thousands)

STATE	Jan. 1980	Feb. 1980	Mar. 1980	Apr. 1980	May 1980	May 1979	May 1980 vs Jan. 1980*	May 1980 vs May 1979
Alabama	1362	1364	1363	1365	1360	1362	–	0
Alaska	158	161	164	165	N.A.	169	+	–
Arizona	995	1003	1008	1008	1003	971	+	+
Arkansas	745	747	754	755	750	756	+	–
California	9726	9728	9789	9804	9804	9624	++	+
Colorado	1243	1238	1248	1251	1252	1208	++	+
Connecticut	1401	1398	1405	1411	1415	1403	+	+
Delaware	252	255	256	255	260	258	+	+
Florida	3499	3528	3549	3538	3515	3539	+	+
Georgia	2123	2132	2138	2137	2130	2116	+	+
Hawaii	404	407	411	411	409	392	+	+
Idaho	331	329	328	326	N.A.	339	–	–
Illinois	4675	4685	4712	4726	4817	4840	++	–
Indiana	2208	2206	2207	2219	2233	2274	+	–
Iowa	1119	1119	1123	1129	1125	1143	+	+
Kansas	948	945	953	954	955	955	+	0
Kentucky	1230	1214	1223	1224	1229	1260	–	–
Louisiana	1512	1512	1521	1525	1517	1492	+	+
Maine	407	408	407	412	416	417	+	–
Maryland	1599	1599	1615	1635	1640	1631	+	+
Massachusetts	2609	2616	2633	2664	2668	2606	++	+
Michigan	3506	3496	3505	3444	3427	3682	–	–
Minnesota	1762	1765	1770	1777	1796	1772	++	–
Mississippi	836	835	837	836	829	843	–	–
Missouri	1961	1960	1985	1999	1989	2022	+	–
Montana	278	277	280	281	287	285	+	+
Nebraska	617	618	624	629	636	635	++	+
Nevada	389	391	395	397	399	381	++	+
New Hampshire	375	377	380	374	N.A.	378	–	–
New Jersey	3002	2996	3014	3029	3048	3023	+	+
New Mexico	463	467	470	474	478	463	++	0
New York	7047	7104	7140	7092	7199	7196	+	+
North Carolina	2395	2395	2410	2426	2421	2371	+	–
North Dakota	240	241	243	246	251	244	++	+
Ohio	4413	4405	4438	4445	4430	4523	+	–
Oklahoma	1104	1107	1120	1129	1133	1085	++	+
Oregon	1053	1048	1052	1041	1043	1049	–	–
Pennsylvania	4779	4754	4773	4817	4831	4863	+	–
Rhode Island	392	391	393	394	392	400	0	–
South Carolina	1184	1186	1194	1202	1200	1182	+	+
South Dakota	234	234	235	238	243	243	++	0
Tennessee	1778	1773	1789	1787	1790	1787	+	+
Texas	5711	5724	5743	5759	5762	5583	++	+
Utah	561	564	563	565	567	546	+	+
Vermont	199	201	201	197	197	195	–	–
Virginia	2097	2088	2098	2108	2118	2102	+	+
Washington	1589	1595	1605	1616	N.A.	1580	+	–
West Virginia	634	629	630	633	636	645	+	–
Wisconsin	1950	1960	1963	1974	1976	1960	++	+
Wyoming	207	208	211	212	216	200	++	+

Employment Increase (+), Decrease (–) or No Change (0), May 1980 vs May 1979 in:

STATE	Construction	Mining	Manufacturing	Transportation & Public Utilities	Wholesale & Retail Trade	Finance, Insurance, Real Estate	Services	Government (federal, state, local)	Leading Employment Sectors	STATE
Alabama	–	+	–	+	+	–	+	+	Mfg, Gov't, W&R Trade	Alabama
Alaska	–	0	–	+	–	–	+	–	Govt, Services, W&R Trade	Alaska
Arizona	–	+	+	+	+	+	+	+	W&R Trade, Gov't, Services	Arizona
Arkansas	–	0	–	–	–	+	+	+	Mfg, W&R Trade, Gov't	Arkansas
California	–	+	–	+	+	+	+	+	W&R Trade, Services, Mfg.	California
Colorado	+	+	+	+	+	+	+	+	W&R Trade, Services, Gov't	Colorado
Connecticut	–	2	+	+	+	+	+	+	Mfg, W&R Trade, Services	Connecticut
Delaware	–	1	0	+	+	+	+	+	Mfg, W&R Trade, Services	Delaware
Florida	+	+	+	+	+	+	+	+	W&R Trade, Services, Gov't	Florida
Georgia	–	–	–	+	+	+	+	+	Mfg, W&R Trade, Gov't	Georgia
Hawaii	+	N.A.	–	+	+	+	+	+	W&R Trade, Services, Gov't	Hawaii
Idaho	–	–	–	–	–	–	–	+	W&R Trade, Gov't, Services	Idaho
Illinois	–	–	–	+	+	+	+	+	Mfg, W&R Trade, Services	Illinois
Indiana	–	+	–	–	–	–	+	+	Mfg, W&R Trade, Gov't	Indiana
Iowa	–	–	–	–	–	–	+	+	W&R Trade, Mfg, Gov't	Iowa
Kansas	–	+	–	–	+	+	+	+	W&R Trade, Gov't, Mfg.	Kansas
Kentucky	–	0	–	–	–	0	+	+	Mfg, W&R Trade, Gov't	Kentucky
Louisiana	+	+	–	+	+	+	+	+	W&R Trade, Gov't, Services	Louisiana
Maine	–	1	–	+	–	+	+	+	Mfg, W&R Trade, Gov't	Maine
Maryland	–	1	–	–	+	+	+	+	Gov't, W&R Trade, Services	Maryland
Massachusetts	+	1	+	+	+	+	+	–	Mfg, Services, W&R Trade	Massachusetts
Michigan	–	+	–	–	–	+	+	+	Mfg, W&R Trade, Gov't	Michigan
Minnesota	–	–	+	–	+	+	+	+	W&R Trade, Mfg, Services	Minnesota
Mississippi	–	+	–	+	–	+	+	+	Mfg, Gov't, W&R Trade	Mississippi
Missouri	–	–	–	–	+	+	+	+	W&R Trade, Mfg, Services	Missouri
Montana	–	+	–	0	0	+	+	+	W&R Trade, Gov't, Services	Montana
Nebraska	–	–	–	+	+	+	+	–	W&R Trade, Gov't, Services	Nebraska
Nevada	–	+	+	+	+	+	+	+	Services, W&R Trade, Gov't	Nevada
New Hampshire	–	–	–	+	–	+	N.A.	+	Mfg, W&R Trade, Services	New Hampshire
New Jersey	+	0	–	+	+	+	+	+	Mfg, W&R Trade, Gov't	New Jersey
New Mexico	–	+	+	+	+	+	+	+	Gov't, W&R Trade, Services	New Mexico
New York	–	+	–	+	–	+	+	+	Services, W&R Trade, Mfg.	New York
North Carolina	–	+	–	+	+	+	+	+	Mfg, W&R Trade, Gov't	North Carolina
North Dakota	–	+	–	+	+	+	+	+	W&R Trade, Gov't, Services	North Dakota
Ohio	–	–	–	+	–	+	+	+	Mfg, W&R Trade, Services	Ohio
Oklahoma	+	+	+	–	+	+	+	+	W&R Trade, Gov't, Services	Oklahoma
Oregon	–	0	–	+	+	+	+	+	W&R Trade, Gov't, Mfg.	Oregon
Pennsylvania	–	–	–	–	–	–	+	–	Mfg, Services, W&R Trade	Pennsylvania
Rhode Island	–	1	–	–	–	–	+	+	Mfg, Services, W&R Trade	Rhode Island
South Carolina	–	0	–	+	+	+	+	+	Mfg, Gov't, W&R Trade	South Carolina
South Dakota	+	+	–	0	–	+	+	–	W&R Trade, Gov't, Services	South Dakota
Tennessee	–	–	–	–	–	0	+	+	Mfg, W&R Trade, Services	Tennessee
Texas	+	+	+	+	+	+	+	+	W&R Trade, Mfg, Services	Texas
Utah	–	+	+	+	+	+	+	+	Gov't, W&R Trade, Services	Utah
Vermont	–	+	+	0	+	+	+	+	Mfg, Services, W&R Trade	Vermont
Virginia	–	–	–	+	+	+	+	+	Gov't, W&R Trade, Mfg.	Virginia
Washington	–	–	–	+	+	+	+	+	W&R Trade, Gov't, Mfg.	Washington
West Virginia	–	–	–	–	+	+	+	+	W&R Trade, Gov't, Mfg.	West Virginia
Wisconsin	–	–	–	–	+	+	+	+	Mfg, W&R Trade, Services	Wisconsin
Wyoming	+	+	+	+	+	+	+	+	W&R Trade, Gov't, Services	Wyoming

*A ++ indicates month-to-month increase from Jan. 1980 to May 1980.
1) Combined with services
2) Combined with construction

Source: Update/The American States, September 1, 1980, pp. 4, 5.

APPENDIX C

STATE SPENDING ON HOSPITAL CARE AND HOSPITALS

According to UPDATE/The American States, expenditures on health and hospitals average around 10% of total state expenditures. Between FY 1973 and FY 1977, the percentage increase was on average 71 percent. However, 14 states registered triple-digit percent increases.

Alaska	(110%)	North Carolina	(140%)
Arizona	(102%)	Ohio	(109%)
Idaho	(100%)	Oregon	(157%)
Iowa	(121%)	South Carolina	(111%)
Nevada	(150%)	South Dakota	(226%)
New Hampshire	(159%)	Texas	(154%)
New Mexico	(204%)	Utah	(119%)

The only states showing a decline in the percentage of expenditures allocated to health and hospitals are Maine and New York.

STATE SPENDING ON HEALTH CARE AND HOSPITALS, FY 1973-77*

State	** Health and Hospital Expenditures	% Change 1973-77	As % of all 1973 expenses	As % of all 1977 expenses
Alabama	230	90	8	9
Alaska	40	110	3	4
Arizona	95	102	5	6
Arkansas	92	96	6	7
California	1,005	83	5	5
Colorado	145	79	7	7
Connecticut	187	45	8	9
Delaware	43	39	7	7
Florida	422	94	7	9
Georgia	304	97	7	10
Hawaii	101	55	7	7
Idaho	36	100	5	5
Illinois	606	61	7	7
Indiana	219	70	7	7
Iowa	157	121	6	7
Kansas	132	80	8	8
Kentucky	136	55	5	5
Louisiana	310	85	8	9
Maine	41	24	6	5
Maryland	316	48	9	9
Massachusetts	382	39	8	8
Michigan	544	46	7	7
Minnesota	225	70	5	6
Mississippi	109	85	5	6
Missouri	209	66	7	8
Montana	37	95	5	6
Nebraska	89	85	8	9
Nevada	30	150	4	6
New Hampshire	57	159	7	10
New Jersey	385	79	6	7
New Mexico	76	204	4	7
New York	1,549	31	9	8
North Carolina	388	140	7	10
North Dakota	30	76	5	5
Ohio	555	109	6	9
Oklahoma	127	55	6	6
Oregon	139	157	5	7
Pennsylvania	805	53	8	9
Rhode Island	95	73	10	12
South Carolina	211	111	8	10
South Dakota	49	226	4	10
Tennessee	194	63	7	8
Texas	687	154	6	9
Utah	68	119	5	8
Vermont	33	65	6	7
Virginia	370	89	9	11
Washington	184	72	5	5
West Virginia	95	83	5	6
Wisconsin	249	64	6	6
Wyoming	20	67	5	5

* The year 1977 is the latest year for which comparable data is available.
** In millions of dollars.

SOURCE: UPDATE/The American States, September 15, 1980, p.6.

Table 10

RATE OF WAGE AND SALARY CHANGES IN EMPLOYMENT COST INDEX

Series	Percent Changes for 3 months ended					Percent Changes for 12 months ended				
	June 1979	September 1979	December 1979	March 1980	June 1980	June 1979	September 1979	December 1979	March 1980	June 1980
All private nonfarm workers 1/	1.9	2.1	2.4	2.4	2.1	7.6	7.7	8.7	9.1	9.3
Workers, by occupational group										
White-collar workers	1.7	2.3	2.4	2.4	1.9	7.0	7.4	8.6	9.2	9.3
Professional and technical workers	1.1	2.7	2.8	3.3	1.8	6.8	7.5	8.8	10.3	11.1
Managers and administrators	1.5	2.0	1.4	2.6	1.6	6.9	7.6	7.4	7.7	7.8
Sales workers	4.2	0.7	3.9	-0.5	2.5	6.7	4.8	8.8	8.6	6.8
Clerical workers	1.4	2.9	2.1	3.0	1.8	7.4	8.5	9.4	9.6	10.1
Blue-collar workers	2.3	2.0	2.5	2.3	2.5	8.4	8.4	9.0	9.4	9.6
Craft and kindred workers	2.1	2.2	1.9	1.7	2.4	8.2	8.3	8.6	8.2	8.5
Operatives, except transport	2.2	1.7	3.1	3.2	2.4	8.6	8.3	9.2	10.5	10.7
Transport equipment operatives	3.5	2.4	2.4	1.2	3.5	8.3	9.5	10.2	9.8	9.9
Nonfarm laborers	2.7	1.7	2.9	2.5	2.4	8.6	8.5	9.1	10.1	9.9
Service workers	0.9	1.1	1.8	3.5	1.1	7.2	5.9	7.2	7.6	7.8
Workers, by industry division										
Manufacturing	1.8	1.8	3.1	2.8	2.0	8.2	8.1	8.6	9.7	10.0
Durables	1.5	2.1	3.3	2.5	2.1	8.2	8.4	9.0	9.7	10.4
Nondurables	2.3	1.2	2.7	3.2	1.9	8.2	7.6	7.8	9.7	9.2
Nonmanufacturing	2.0	2.3	2.0	2.2	2.1	7.2	7.5	8.8	8.8	8.9
Construction	2.6	2.0	1.1	1.2	2.9	7.6	7.2	7.2	7.1	7.5
Transportation and public utilities	1.6	2.9	2.0	2.5	2.3	8.4	9.2	9.4	9.3	10.1
Wholesale and retail trade	2.4	1.9	1.3	2.6	1.9	7.0	7.7	7.9	8.4	7.8
Wholesale trade	2.9	1.2	2.1	2.9	2.7	7.7	7.8	7.9	9.4	9.2
Retail trade	2.3	2.1	1.0	2.4	1.5	6.7	7.7	7.9	8.0	7.3
Finance, insurance, and real estate	3.2	1.9	4.3	0.4	2.7	*	*	13.2	10.2	9.6
Services	1.1	2.6	2.5	2.7	1.6	6.4	6.6	8.5	9.2	9.8

Series	Percent Changes for									
	3 months ended					12 months ended				
	June 1979	September 1979	December 1979	March 1980	June 1980	June 1979	September 1979	December 1979	March 1980	June 1980
Workers, by region										
Northeast	1.7	1.7	2.1	2.5	2.1	6.9	6.9	7.3	8.3	8.7
South	1.7	1.7	2.4	2.8	1.9	8.3	7.7	8.5	8.8	9.0
North Central	2.5	2.0	2.6	2.4	2.0	7.6	8.2	9.4	9.9	9.3
West	2.0	2.5	1.8	2.6	2.4	7.7	8.2	8.5	9.2	9.6
Workers, by bargaining status										
Union	2.1	2.2	2.6	2.3	2.8	8.3	8.4	9.0	9.5	10.2
Manufacturing	2.0	1.9	3.4	2.6	2.8	9.1	8.6	9.4	10.3	11.1
Nonmanufacturing	2.2	2.5	1.7	2.0	2.8	7.6	8.2	8.5	8.8	9.5
Nonunion	1.9	1.9	2.3	2.5	1.7	7.2	7.3	8.5	8.9	8.7
Manufacturing	1.7	1.6	2.7	3.0	1.4	7.4	7.7	7.9	9.3	9.0
Nonmanufacturing	2.0	2.1	2.1	2.3	1.9	7.1	7.1	8.8	8.8	8.6
Workers, by area										
Metropolian areas	2.0	2.2	2.5	2.1	2.2	7.7	7.9	8.9	9.1	9.3
Other areas	2.1	1.6	1.9	3.6	1.6	7.4	7.3	7.9	9.5	8.9

* Not available

1/ Excludes private household workers.

Source: Bureau of Labor Statistics

TABLES ON MEDICAL CARE PRICES, UTILIZATION, AND COST

Consumer Price Index

In general, the July medical care component of the CPI did not contain any surprises. Hospital and medical care prices were sharply higher. However, this reflected fiscal year adjustments. The prices of physician services and dental services increased at a moderate pace, in contrast to behavior earlier in the year. Prices of medical care commodities continued to increased rapidly.

Table 9

AUGUST CONSUMER PRICE INDEX (CPI-U): U.S. CITY AVERAGE

GROUP	Unadjusted Percentage Change 12 Months	Unadjusted Percentage Change 1 Month	Seasonally Adjusted Percentage Change From 1 Month Ago	Three Month Seasonally Adjusted
All Items	12.8	0.6	0.7	6.9
Food and Beverages	9.5	1.5	1.7	13.7
Housing	14.8	0.3	0.1	5.0
Apparel and Upkeep	7.4	1.4	0.6	4.1
Transportation	15.1	0.7	0.9	4.1
Medical Care	11.2	0.6	0.7	8.0
Entertainment	9.4	0.7	0.8	9.1
Energy	25.1	0.1	0.2	3.1

Source: Bureau of Labor Statistics. Figures obtained from a telephone conversation with a member of the BLS staff.

Figure I

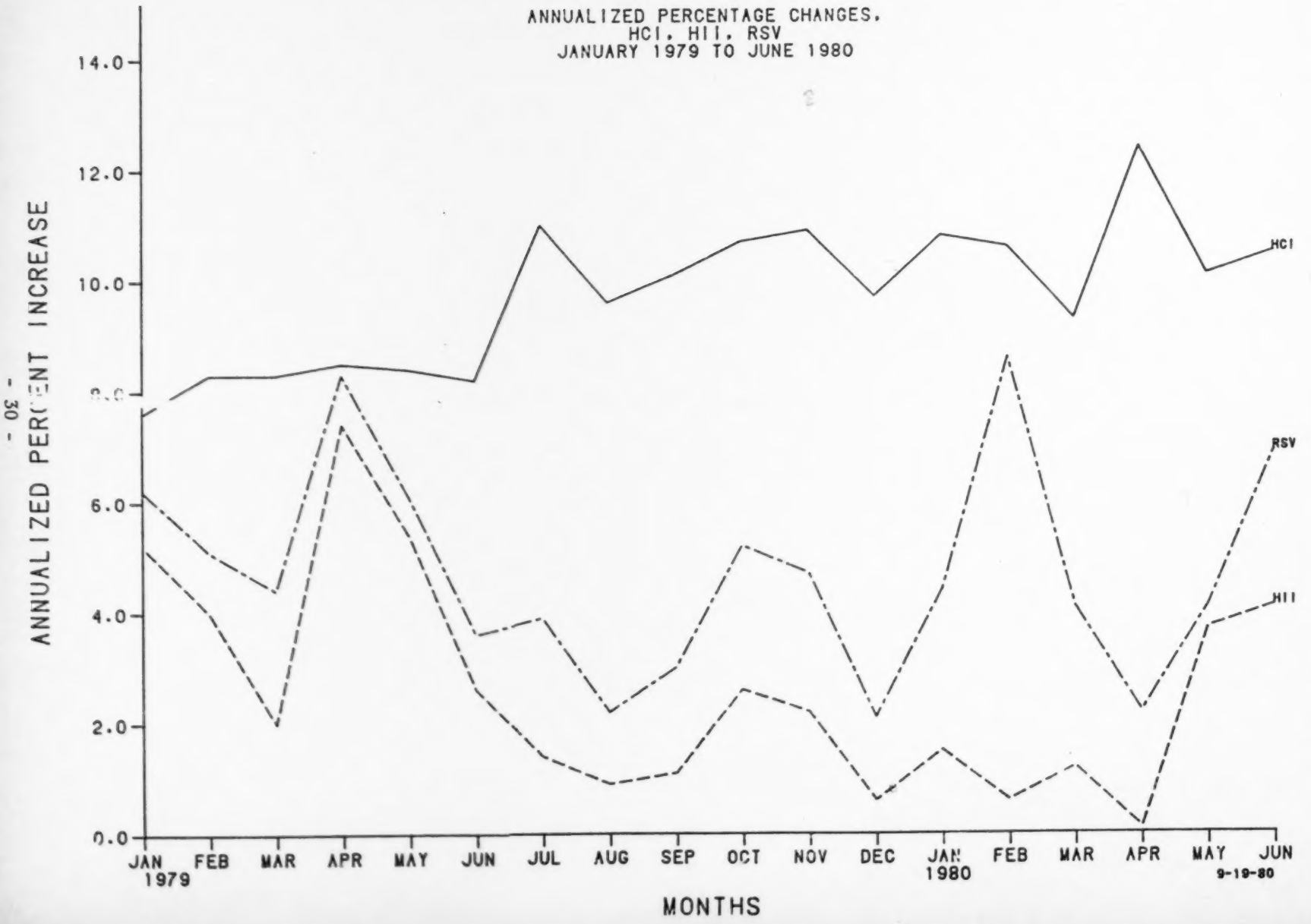

ANNUALIZED PERCENTAGE CHANGES.
HCI. HII. RSV
JANUARY 1979 TO JUNE 1980
ANNUALIZED PERCENT INCREASE
14.0
12.0
10.0
6.0
4.0
2.0
0.0
HCI
RSV
HII
JAN 1979
FEB
MAR
APR
MAY
JUN
JUL
AUG
SEP
OCT
NOV
DEC
JAN 1980
FEB
MAR
APR
MAY
JUN
9-19-80
MONTHS

Table 12

CONSUMER PRICE INDEX OF ALL URBAN CONSUMERS

U.S. CITY AVERAGE, UNADJUSTED

	JULY 1980		
	INDEX 1967 = 100	PERCENTAGE CHANGE FOR 1 MONTH	12 MONTHS
All Items	247.8	0.1	13.2
Medical Care	266.6	0.7	11.1
Medical Care Commodities	169.1	0.7	9.7
Medical Care Services	288.0	0.7	11.4
Professional Services	253.5	0.7	11.4
Physician Services	270.9	0.6	10.7
Dentist Services	241.1	0.3	12.0
Other Professional Services	125.0	1.7	12.1
Other Medical Care Services	329.7	0.8	11.5
Hospital and Other Medical Care Services	133.4	1.5	13.7
Hospital Room	418.2	1.4	13.1
Other Hospital and Medical Care Services	132.8	1.7	14.1
Services	272.4	-0.7	16.1
Services Less Medical Care	268.9	-0.8	16.6

	AUGUST 1980		
	INDEX 1967 = 100	PERCENTAGE CHANGE FOR 1 MONTH	12 MONTHS
All Items	249.4	0.6	12.8
Medical Care	268.4	0.7	11.0
Medical Care Commodities	170.2	0.7	9.8
Medical Care Services	289.8	0.6	11.2
Professional Services	254.7	0.5	11.3
Physician Services	272.2	0.5	10.4
Dentist Services	242.2	0.5	12.1
Other Professional Services	126.0	0.8	12.6
Other Medical Care Services	332.3	0.8	11.1
Hospital and Other Medical Care Services	135.4	1.5	14.2
Hospital Room	424.0	1.4	13.3
Other Hospital and Medical Care Services	135.1	1.7	15.1
Services	272.5	0.0	14.7
Services Less Medical Care	268.7	0.1	15.0

SOURCE: Bureau of Labor Statistics.

TABLE 13

PERCENT CHANGE IN CONSUMER PRICE INDEX (CPI-U):

Cross Classification of Region

	June 1980 to August 1980		August 1979 to August 1980	
	All Items	Medical Care	All Items	Medical Care
North East	1.9	1.5	13.3	9.6
North Central	0.1	2.1	12.1	11.4
West	0.1	1.2	13.6	11.9
South	0.6	0.9	12.4	11.2

	May 1980 to July 1980		July 1979 to July 1980	
	All Items	Medical Care	All Items	Medical Care
North East	2.1	1.2	12.9	9.6
North Central	1.0	1.4	12.6	11.7
West	0.4	0.9	14.8	12.3
South	1.1	1.3	12.7	11.3

Source: Bureau of Labor Statistics. Figures obtained from a telephone conversation with a member of the BLS staff.

Table 14

Percent Change in CPI-U, Selected Cities

	June 1980 to August 1980		August 1979 to August 1980	
	Medical Care	All Items	Medical Care	All Items
Philadelphia	4.4	1.4	10.4	13.0
Pittsburgh	3.7	1.9	11.7	14.4
Dallas-Fort Worth	3.1	0.8	13.1	16.0
Honolulu	2.1	1.1	8.7	11.1
Atlanta	1.9	1.8	11.0	13.6
Cleveland	1.8	1.5	10.7	14.7
All Cities	1.4	0.7	11.0	12.8
Kansas City	1.4	1.2	12.0	11.7
Chicago-Northwestern Indiana	1.3	-1.2	13.0	12.2
Buffalo	1.2	0.6	6.6	10.3
New York-Northeastern New Jersey	1.0	1.5	10.3	11.8
Los Angeles-Long Beach-Anaheim	0.9	-1.1	12.4	13.7
Houston	0.5	0.8	10.5	11.6
San Francisco-Oakland	0.5	1.2	10.9	15.0
Detroit	0.4	-0.6	7.8	14.8

Source: Bureau of Labor Statistics. Figures obtained from a telephone conversation with a member of the BLS staff.

Table 15

Percentage Change in the CPI-U,
U.S. City Average and Selected Areas

	May 1980 to July 1980		July 1979 to July 1980	
	Medical Care	All Items	Medical Care	All Items
Northeast, Pa. (Scranton)	7.6	3.1	16.4	13.3
Philadelphia, Pa.	3.6	2.0	10.0	13.4
Milwaukee, Wi.	2.7	0.5	11.6	13.0
St. Louis, Mo.	1.8	1.3	11.9	13.0
Seattle - Everett, Wa.	1.7	2.2	13.3	17.3
Cincinnati, Oh. - Ky. - In.	1.3	1.0	10.4	14.2
Detroit, Mi.	1.3	2.1	8.6	19.2
U.S. City Average	1.2	1.2	11.3	13.3
Los Angeles, - Long Beach - Anaheim, Ca.	1.2	-0.2	12.6	17.5
Anchorage, Al.	1.1	1.7	9.4	10.1
Washington, D.C. - Md. - Va.	1.0	2.5	10.0	12.2
Chicago, Il. - N.W. Ind.	0.7	1.5	12.8	16.3
San Diego, Ca.	0.5	0.1	10.5	14.3
Portland, Or.	0.4	-1.8	12.8	11.1
New York - Northeastern N.J.	0.3	1.9	10.0	11.6
Denver - Boulder, Co.	0.1	1.4	10.4	10.6
Boston, Ma.	-0.3	1.7	9.4	12.5
Miami, Fl.	-0.3	3.0	10.2	15.5
Baltimore, Md.*	-0.7	1.3	9.8	14.2

* A BLS staff member attributed the decline in the Baltimore CPI medical care index between May 1980 and July 1980 to the activities of the Maryland Rate Review Commission. Prices of hospital and other medical care health insurance declined during third period.

Source: Bureau of Labor Statistics. Figures obtained from a telephone conversation with a member of the BLS staff.

Report on Hospital Performance, June 1980

Total hospital expenses and inpatient hospital expenses both increased 15.3 percent in June 1980, compared to 13.0 percent in June 1979. The AHA attributed the faster growth to higher wages, employment, supply expenses and utilization.

Utilization increased sharply in June 1980. Admissions rose 5.5 percent, compared to 0.9 percent in June 1979. The 1980 rate of increase was the second largest in almost 3 years, and largely reflected accelerated utilization of the under - 65 population. Patient census, surgical operations and births also increased more rapidly than in the previous year.

The rate of increase in the price of the AHA hospital market basket slowed from its peak rate reached in March 1980. However, prices continued to rise more rapidly than last year. For example, in June 1980, the price of the AHA market basket orse 11.6 percent, compared to 10.1 percent in June 1979. The nonlabor component of that basket accelerated rapidly, from 10.7 percent in June 1979 to 14.5 percent in June 1980, due to higher energy, capital and housekeeping supply prices.

The nursing shortage continued to put upward pressure on all hospital wage rates. In addition, increased utilization caused hospitals to expand their work force. As a result, hospital labor expenses increased more rapidly than last year, e.g. 15.0 percent in June 1980 vs. 13.6 percent in June 1979.

Several hospital analysts are predicting higher hospital cost increases in the months ahead due to higher food, labor, and capital costs.

Table 16

Selected Hospital Performance Indicators: June 1979 and 1980 and Calendar Years 1978 and 1979

	Percent Change			
	Month of June		Year-to-date	
	1979	1980	1979	1980
Inpatient Statistics				
Inpatient expenses	13.0	15.3	12.8	15.5
Inpatient expenses per admission	12.0	9.4	10.3	11.9
Admissions	0.9	5.5	2.3	3.3
Average length of stay	0.7	-2.6	-1.2	0.0
Over-65 admissions	4.4	6.7	4.3	6.9
ALOS 65+	0.1	-3.3	-1.8	-0.1
Under-65 admissions	-0.3	5.0	1.5	1.9
ALOS 0-64	0.1	-2.5	-1.3	-0.9
Births	3.5	3.8	5.4	3.0
Surgical operations	0.4	3.1	4.7	3.9
Beds	0.9	0.8	0.9	0.6
Census	1.6	2.7	1.1	2.7
Percent occupancy	74.1	75.6	75.3	77.4
Hospital Market Basket				
Total market basket	10.1	11.6	9.9	12.5
Labor component	9.7	9.4	9.2	11.0
Nonlabor component	10.7	14.5	10.8	15.3
Total Expenses - Inpatient and Outpatient				
Total expenses	13.0	15.3	13.2	15.7
Outpatient visits	-3.0	1.6	-0.8	3.2

Source: American Hospital Association, TRENDS, No. 34, P. 5.

AHA Hospital Cost (HCI) and Hospital Intensity (HII) Indexes - See Table .

The Hospital Cost Index (HCI) reflects changes in the price of a hospital market basket consisting of 46 procedures, the hospital intensity index (HII), reflects changes in the quantity of these same procedures, and the real service volume index (RSV) adjusts the intensity index (HII) for changes in seasonally adjusted patient days.

Percent Change in Hospital Cost and Intensity Index

Table 17

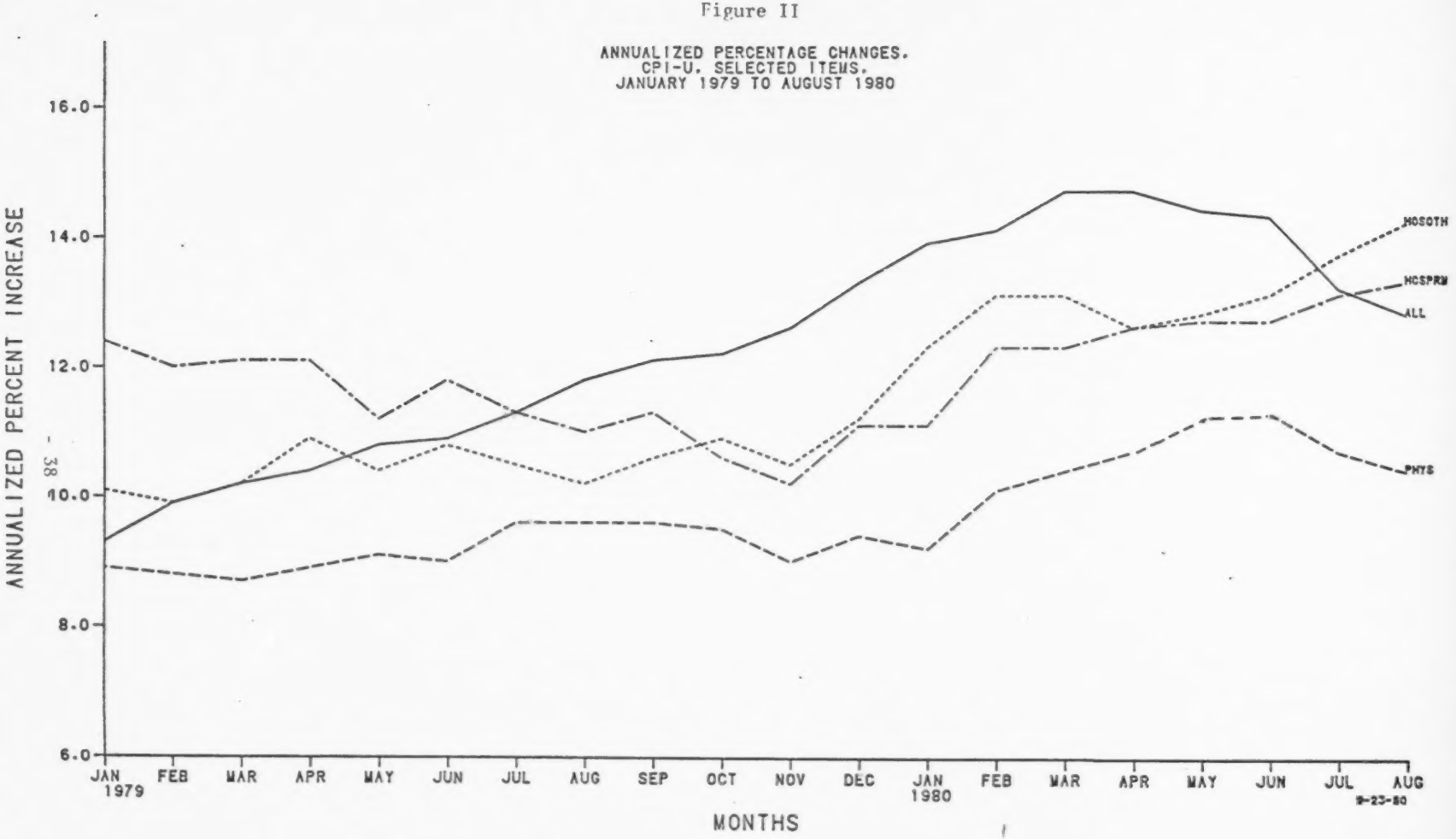
	12 Month Period Ending		
	April 1980	May 1980	June 1980
Hospital Cost Index (HCI)	12.43 r.	10.06	10.53 p.
Hospital Intensity Index (HII)	0.11 r.	3.66	4.05 p.
Real Service Volume (RSV)	2.18 r.	4.06	6.88 p.

r. revised

p. preliminary

Source: American Hospital Association.

Figure II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16.0
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HOSOTH
HOSPRM
ALL
PHYS
JAN 1979
FEB
MAR
APR
MAY
JUN
JUL
AUG
SEP
OCT
NOV
DEC
JAN 1980
FEB
MAR
APR
MAY
JUN
JUL
AUG
9-23-80
MONTHS

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